CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

6 June 1998

RPSGB to finalise major CPD pilot

Picture postcard to the PM for RPM campaign

OTC 'morning after' pill debate to be renewed

Update: ways to treat when stroke strikes

Gehe's acquisition diet builds up its empire

Business statistics: 'feel good' factor on the wane

AHP and Monsanto in $96bn merger deal

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The notion that continuing professional development should be mandatory is losing ground. Instead, opinion formers are favouring a voluntary system, which would rely on the pharmacist's professional conscience to maintain his or her knowledge of pharmacy. The Society is boxing clever as it announces the introduction of a pilot CPD scheme early next year (p4). Such a scheme will be 'voluntary', but could become compulsory if contractors wish to be able to provide NHS services. And for employee pharmacists to remain in employment, terms and conditions could be imposed by the employer relating to CPD standards. It may even provide a career path in the community sector allowing employees to progress without having to abandon practice to take on management positions – surely a way of keeping younger members in the profession.

It is easy to find fault with a system that has not even started. For example, if manpower levels don't improve, it could be difficult for employers to make employees comply with the standards. But pilots are designed to identify problems as well as to provide answers. Rather, the Society should be complimented as the proposed scheme is a way of introducing a practice element into CPD. It can be relatively easy to complete the 30 hours of continuing education recommended in the Code of Ethics. But if the knowledge presented in those 30 hours is not used, it will be rapidly lost. Like a candidate cramming for an exam, it only shows short-term memory retention.

The term 'mandatory' questions the professional responsibility of a self-regulatory profession. With the scheme being voluntary, the head of the Society's education division, Dr Robert Dewdney, suggests it is unlikely that the Society will need to impose sanctions or strike members off as the scheme itself will provide the incentive if pharmacists wish to be paid. What might happen, though, is that there will be a spectrum of pharmacies and pharmacists, ranging from the very good to those who comply with a bare minimum. So long as a suitable system is developed for accrediting, 'certifying' and publicising CPD, then the public will be able to select those pharmacies it wants to use. Survival of the fittest comes to mind.

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Also in this week's issue...

● The third module in the Boehringer Mannheim *C&D* series on 'Pharmaceutical Care of the Diabetic Patient' (see centre pages). To enrol, complete the coupon on p36.

REGULARS

Pharmed seeks health professions' feedback

Pharmed has set up an 'Early Adopter Programme' to encourage feedback from health professionals about the development of its secure electronic data transmission system.

Following the establishment of a national advisory panel consisting of representatives from professional bodies, PEAP will provide a means for pharmacists, GPs and other health care professionals to have a say in the Pharmed system.

PEAP will provide members with regular updates regarding the advisory panel's activities and meetings, as well as being able to elect two representatives onto the panel. In addition, members will have unrestricted access to Pharmed's Internet pages, preferential attendance at Pharmed road shows later in the year, free subscription to a quarterly newsletter and copies of Pharmed literature as published.

Pharmed stresses there is no obligation for members to purchase Pharmed services. Instead, company director Ian Moody says: "What we want to do is give health care professionals access to the knowledge they need in order to make informed decisions about using electronic prescribing and electronic messaging in their pharmacy or surgery."

Pharmed was established last summer to develop open industry standards regarding electronic communication, focusing initially on electronic prescribing and the transfer of data between general practice and pharmacy via the NHS-Net or the Internet.

Further details regarding registration can be obtained from Pharmed on 01527 871958 or on Pharmed's Internet site at *www.pharmed.org.uk*.

Asda controversy in Cornwall

Asda has applied for a pharmacy contract in its Penryn superstore, despite planning conditions preventing a pharmacy from opening.

Local pharmacies have opposed the contract application, which was to be considered this week by a Cornwall Health Authority subcommittee. A final decision is expected in the first week of July.

When the store was built last year, planning permission excluded a pharmacy and post office, but Asda will re-apply if a dispensing contract is granted.

Major CPD pilot on the way

Pharmacists will be recruited soon for a major continuing professional development pilot.

They will identify their own training needs, following the 'Medicines, Ethics and Practice' guide's recommendations for ensuring professional competence, and will be subject to peer review. The ultimate aim is to introduce a voluntary scheme for all practising pharmacists but, in effect, it is likely to become unavoidable for pharmacists wishing to contract to the NHS or progress up the career ladder as an employee.

A Royal Pharmaceutical Society steering committee is to meet on June 15 to finalise details of the pilot, which is due to start in January. Dr Robert Dewdney, head of the Society's education division, told *C&D* that the pilot would involve "hundreds rather than thousands" of community and hospital pharmacists from three or four large regions of the UK, and the pilot would last from six to nine months. The pharmacists would look at their own immediate practice and career plans and would decide what courses, other training or experiences such as work-shadowing were needed. Although the Society recommends 30 hours of continuing education a year, it would not lay down time limits for the CPD scheme as this would depend on each individual's differing needs. "Someone wishing to set up a full domiciliary clinical pharmacy service might need many hundreds of hours," he said.

When the scheme is fully implemented a sample of pharmacists would be selected at intervals to "share their CPD experience with their fellow professionals". This would not involve an examination or face to face interview, but there would be some way, yet to be decided, of assessing the quality of their personal development. Administered by the Society, the assessment might involve submitting a CPD portfolio or answering a questionnaire.

"If a pharmacist appeared to be having a tough time, the Society would offer additional support," said Dr Dewdney. "Conversely, where there were astonishing examples of good practice then we would be able to learn from these models for the future." For pharmacists who failed to come up to scratch after extra support, the Society had still to decide "what advantages that person should be denied". It would be unlikely to mean sanctions or striking off.

When asked if the scheme would become mandatory, Dr Dewdney said it would be "a voluntary system that everyone would feel they had to sign up for". A demand for quality from outside the profession – including perhaps health authorities – would have the knock-on effect of contractors having to be of a certain standard and employers wanting to employ only those pharmacists with evidence of CPD good practice.

Support for a non-pharmacist S&R mixed

Pharmacy proprietors' and managers' support for the appointment of a non-pharmacist secretary and registrar, to succeed John Ferguson, is mixed, a *Chemist & Druggist* survey has found.

Just over half (54 per cent) of respondents believed that the best applicant should be chosen as registrar of the Royal Pharmaceutical Society, as opposed to the best pharmacist. Two-fifths (40 per cent) of respondents did not agree, with the remainder not stating an answer.

When asked about their feelings about the prospect of the secretary and registrar of the RPSGB being a non-pharmacist, of the 166 respondents, 40 per cent were totally opposed. Only 4 per cent thought it was a good idea. One respondent thought that such an appointment was essential. Those describing themselves as not enthusiastic (27 per cent) were similar in number to those not minding (26 per cent).

The survey was carried out as part of the *Chemist & Druggist* Business Trends Survey 4th Quarter 1997, supported by AAH (see also **Business** pages in next week's issue).

The survey was sent out in March just after it was announced that Mr Ferguson was to retire. It was expected that the appointment would be made by the end of May, but the Society had yet to make an announcement as *C&D* went to press on Wednesday.

Dr Paul Little (fourth from left) and his team of researchers from Southampton University have won the Royal College of General Practioner's 'Research paper of the year' award. Their research looked at antibiotic prescribing strategies in the treatment of sore throats and concluded the duration of sore throats was not shortened with antibiotic treatment. The award is sponsored by Boots the Chemists

Patel new president

Hemant Patel is the new president of the Royal Pharmaceutical Society and succeeds Peter Curphey. David Allen is the new vice-president. Geoffrey Booth stays as treasurer and John Ferguson is re-appointed secretary.

Christine Glover, who has served as vice president since last June, was not re-appointed to the executive at the new Council's first meeting this week.

The appointments have come as a surprise, as one of the Banks Report recommendations, which were accepted by Council last September, is that the president would ideally serve two or three terms, subject to re-election. It has also been normal practice for the vice president to assume the mantel of president.

People taking risks in sun despite knowing consequences

Many people are still taking risks with their health in pursuit of a suntan, despite there being a high level of awareness of the dangers of sunbathing, a survey has found.

'Sun exposure: adults' behaviour and knowledge 1997' was released by the Department of Health this week and is based on a survey about skin cancer, conducted by the Office for National Statistics last September. It found that over 90 per cent of adults are aware of the publicity about risks associated with exposure to the sun, but a tan remains desirable for a substantial majority – over a third of men, and nearly half of women who did not have naturally black or brown skin colouring had tried to get a tan the previous year.

The problem is more pronounced among people aged 16-24, with over half the males and over three-quarters of women in this age group claiming to have tried to get a suntan in the past year. About a quarter of men and a fifth of women had been sunburnt in the previous 12 months. Men were also less likely to know about sun protection factors.

Health service fraud supremo appointed

The Government appointed James Gee as its health service fraud supremo last week.

His job is to uncover, prevent and deter health service fraud and advise ministers on strategy to achieve this. He will report directly to health minister Alan Milburn and will be supported by staff from the NHS Executive.

The Government views the appointment as the first step in actioning its prescription fraud programme, which was proposed last summer. Losses from fraud in the Family Health Services are estimated to be £85-115 million from prescription form and patient charge evasion.

Since 1997, Mr Gee has been a special adviser on fraud to the minister of state for welfare reform, Frank Field. From 1994-96, he was the fraud investigation manager with the London Borough of Haringey and, from 1990-94, he held this post in the Borough of Islington.

"One of my first tasks will be to set out a strategic vision of how fraud can be tackled across the family health services, setting out the responsibilities we expect of patients and staff, and benefits the service will see from tackling fraud," says Mr Gee.

NPA director John D'Arcy said: "Any measures which serve to clamp down on fraud within the NHS are to be welcomed. However, the NPA hopes the implementation of any measures will not prejudice the trust associated with the relationship between patients and pharmacists."

RPSGB appoints nine fellows

The Royal Pharmaceutical Society has designated nine of its members as fellows, six of whom were designated for distinction in the profession of pharmacy.

The six were John Carr, Marshall Davies, David Plumb, Linda Stephens, Joy Wingfield and Gerald Zeidman. Stephen Hudson received his fellowship for distinction in the practice of pharmacy. Alexander Davidson received his for distinction in the science of pharmacy and Rosemarie Biggs hers for distinction in both the practice and profession of pharmacy.

Mr Carr, was a member of Council from 1991-97. He is also a former president of the Joint Boots Pharmacists' Association. Mr Davies is a member of Council and, until this year, was the superintendent pharmacist of Boots the Chemists. Professor Hudson is a professor of clinical pharmacy practice at the University of Strathclyde and a founder member of the UKCPA. Linda Stephens was the chairman of the UKCPA from 1994-97.

Postcards from the edge?

Pharmacists are to be asked to send the Prime Minister postcards featuring consumer affairs minister Nigel Griffiths to highlight the resale price maintenance turnabout by Labour.

In opposition, Mr Griffiths was among a group of MPs who presented a petition with National Pharmaceutical Director John D'Arcy to the Office of Fair Trading, calling for the protection of RPM. The postcard being distributed next week shows a picture of the event. It is hoped by returning it with 20 signatures collected from customers, the Prime Minister will be reminded of Labour's pre-election pledges.

CPAG chairman David Sharpe told *C&D* on Tuesday: "We are reaching a critical stage in our campaign as the Competition Bill is now in standing committee. We want to bring our concerns to the attention of the Prime Minister. What better way is there than sending several thousand postcards to him."

A letter from Mr D'Arcy accompanying the card says that Mr Blair must be made aware of the strength of feeling of community pharmacy. He is asking pharmacists to display the card in the pharmacy and get 20 customers to sign the back of it. This should then be returned to CPAG which will then deliver them to Downing Street.

The postcard shows from left: Ray Michie MP (Sheffield Healey), Nigel Griffiths MP (at the time shadow Consumer Minister), John D'Arcy (then deputy director of the NPA), Alan Meal MP (Mansfield) and Bridget Prentice MP (Lewisham East), outside the Office of Fair Trading in September 1996

OTC PC4 campaign renewed

A campaign calling for OTC availability of the morning after pill is to be re-launched next week.

The Birth Control Trust is renewing its call for emergency contraception to be available from pharmacies, following a move earlier this year when an Early Day Motion was tabled in the House of Commons in support of deregulation (*C&D* February 7, p5). Another EDM is to be tabled by Liberal Democrat MP Jenny Tonge, who was a co-signatory of the January EDM.

Besides raising public awareness, the trust is hoping to persuade GPs and other health professionals to write to their MPs to encourage them to sign the EDM.

The campaign re-launch coincides with the publication of a booklet on emergency contraception by the BCT. Roger Odd, head of practice at the Royal Pharmaceutical Society is expected to speak about the pharmacist's perspective on the initiative. The assistant secretary general of the International Planned Parenthood Federation, Pramilla Senanayake, is also expected to attend the launch, to speak about a scheme that is operating via pharmacies in Washington, DC.

In February, Mr Odd expressed support for the first EDM. However, concern was raised by pharmacists, including *C&D* readers who were against the deregulation of the morning after pill. Schering had reservations about re-scheduling its PC4 contraceptive as a Pharmacy medicine.

Answering these points, a Trust spokesman said he realised not all pharmacists would be keen to supply emergency contraception OTC and he believes Schering will be more sympathetic to the arguments being put forward. The spokesman stressed that the trust is not seeking to widen the campaign to call for other oral contraceptives to be made available OTC.

PIANA targets – the state of play

The Royal Pharmaceutical Society has issued a summary of action taken and action planned on the targets outlined in 'Building the future', the PIANA strategy document published last September. The Council promised to start work on 25 targets in 1997-98.

The five key themes were:

Management of prescribed medicines The target was to develop a strategy to promote prescribing by pharmacists. Discussions are planned with the Government, other professions and patient groups after publication of the final report of the Crown Review of prescribing. This month preliminary work on options for pharmacist prescribing will be completed.The pilots on repeat dispensing/prescribing options by pharmacists should be evaluated by December.

Management of long-term conditions Pharmacists are already involved in projects helping patients with chronic conditions such as diabetes. Future action will identify a short list of conditions in which pharmacists could promote health gain. A literature review should provide examples of good practice. A multidisciplinary group will be set up to discuss commissioning advice to support such roles.

Proposals are being developed for a repeat dispensing system to be in place in most pharmacies by 2001. There will be discussions with pharmaceutical organisations, other professions and patients' representatives, and guidelines drawn up for consultation. Proposals will be considered in the light of the Crown Review.

Management of common ailments Principles have been agreed with the British Medical Association and the Royal College of General Practitioners for developing the role of pharmacies as the first port of call for common ailments. The Society's group on achieving the optimum use of non-prescription medicines will identify ways of promoting the pharmacist's role to the public, seek support from the Government and consider packs to help pharmacists co-ordinate activities.

The Society's leaflet 'Pharmacy first for help with common ailments' will be distributed through pharmacies and GP surgeries and possibly sold to HAs. The secretary and registrar is on the editorial board of a self-care publication marking the 50th anniversary of the NHS. The pharmaceutical industry will be informed about the progress.

Promotion and support of healthy lifestyles A group, set up by the Society and partly funded by the DoH, is promoting pharmacists' involvement in supporting healthy lifestyles. Claire Anderson, King's College, London, is facilitating a project preparing guidelines on the role of pharmacists in health promotion. The Pharmacy Healthcare Scheme has commissioned the NPA to pilot community pharmacy involvement in one HA area.

Advice and support for other health professionals In July the Society will publish a survey of pharmacy involvement in multi-professional clinical audit. Pharmacy, medical and nursing organisations have agreed a statement on 'Responsible self-care including self-medication' and a working group will pursue these principles.

PCG recognition

The Pharmaceutical Services Negotiating Committee has published a new document to present the case for community pharmacists to be included in the management of primary care groups.

The document, 'What community pharmacists can bring to a PCG board', sets out reasons such as pharmacists' business and management abilities, their communication skills, and their accessibility.

Copies were sent to local pharmaceutical committee secretaries on Tuesday.

More funding for complementary health

The Department of Health is providing a further £25,000 to help co-ordinate professional and regulatory activity in complementary medicine.

It has already given £25,000 for a survey of the professional organisation of complementary medicine, carried out by Exeter University's Centre for Complementary Health Studies. The new funding will be used to follow up the research.

Health secretary Frank Dobson said last week that alternative health care practitioners should be subject to rigorous standards in the same way as orthodox ones. Some might want to follow the examples of osteopaths and chiropractors who are opening statutory registers this year. Others might prefer voluntary systems, he said.

"There is nothing wrong with the voluntary approach providing they offer substantial safeguards to the public including reliable professional registers," he told a London conference on the integration of complementary and orthodox health care.

NI stats

There were 1,915,016 items dispensed from 1,155,985 prescription forms in Northern Ireland in March. The ingredient cost was £18.14 million (£16.97m net). The discount £1.176m, with oncost and other payments totalling £2.953m. The gross cost was £19.92m (£19.34m net). Gross cost per prescription was £10.4015 with ingredient cost £9.4736. The net ingredient cost per prescription was £8.8593.

Slow sodium price

Following a price increase for slow sodium tablets from £0.55 to £6.05 the Department of Health has written to HK Pharma to ask why the price increased by 1,000 per cent between March and May 1998. Health minister Alan Milburn said on Tuesday that DoH officials had written to the company on April 28 but so far HK Pharma had not replied.

HAZ II

Bids for the second wave of Health Action Zones, to come into effect from April 1, 1999, are being sought from 34 areas across England. It is anticipated up to 15 will be invited to develop a full proposal. Key issues to be addressed include identifying and addressing public health needs and developing partnerships to help improve local health. Eleven HAZs commenced work on April 1.

GP stats

The number of GPs in England rose 0.9 per cent between 1996 and 1997, and by an average of 0.8 per cent over the past ten years with all the increase occurring among women, the Department of Health announced last week. Last year, 32 per cent of GPs were women, compared to 23 per cent in 1987.

Watchdog in doghouse

BBC television's consumer affairs programme 'Watchdog', the "self-appointed crusaders of consumer rights", was expected to apologise to Scyence Skin Care plc on Wednesday over broadcasting "unfounded defamatory allegations" about the testing and promotion of Scyence's Servital Anti-Aging Tissue Defence skin cream. Scyence says the BBC presented a series of falsehoods as fact, albeit relying in good faith on information supplied to them by third parties.

N IRELAND NOTEBOOK

Payment for CE course attendance

A headline in *C&D* in February announced that N Ireland pharmacists are to get paid $400 per year for attending NICPPET courses. I was delighted: now the real cost of course attendance will be covered! My congratulations to the PPET Committee for achieving this concession.

It might, therefore, seem gratuitous to complain in the face of this positive advance, but I shall. Only a few days ago I received a cheque from NICPPET for $20.08. This was a locum payment for a half-day course held from 2-5pm.

No locum I know will work a half-day, but even if they did, to get to a meeting in Belfast for 1.30pm, I must leave my shop before 12.30pm – hardly a half-day commitment. In this light, the payment is unreasonable, and a full-day's fee should be made available, or perhaps only full-day courses should be organised.

Doctors have always had enviable financial support for continuing education. If they notch up 30 hours of CE in a year, they are paid $2,500. That equates to $85 per hour compared to our $20 per hour which is only payable for about 20 hours per year (four days of five hours). We have still some way to go to get parity.

I am confused by the term 'eligible pharmacist'. Contractors provide pharmaceutical services,

We have still some way to go to get parity with doctors' support

therefore these moneys should go through us. If they do not, the payment is likely to lead to some employees pocketing the money. I am also at a loss to understand why locum pharmacists need this payment. Locums are simply going to attend four one day courses per year and get paid, whereas I only cover my costs. This has been badly thought out.

Having said all that, I am encouraged by the work done by CPPET. It is in tune with what pharmacists want. I like the new idea of a number of courses linking together so that a subject may be studied in greater detail. I find the IT programme particularly attractive, but I am having difficulty getting onto the courses on offer. Most likely they are filled with locum pharmacists!

Written by a practising N Ireland community pharmacist

Topical Reflections

On the end of the telephone

One of the many frustrations of my daily practice is being unable to contact patients by telephone because their number is ex-directory. I can fully understand, as a constant target of the cold sell double glazing salesman, why an increasing number of people wish to withhold their telephone number.

However, when the unexpected happens and I am refused a telephone number, then a minor problem that would have only taken a few seconds to solve could require a drive across town, with no guarantee that the door bell will be answered!

Of greater concern are those rare occasions when the withholding of a telephone number could present positive danger and then ... panic! This has happened to me in the past. Not often, I am glad to say, but once is too often when it is a genuine emergency and you cannot contact the patient!

That problem has now been reduced, with the announcement that pharmacists will be able to access ex-directory numbers in 'life or death' emergencies (*C&D* May 30, p4).

The change is a result of representations from the National Pharmaceutical Association to British Telecom and, even if the facility does seem to have been a little belatedly granted, my congratulations must go to the NPA for quietly achieving this agreement.

It should not only benefit patients, but demonstrate the acceptance by others of the equality of responsibility that the community pharmacist now shares with other members of the health services.

Keeping advice up-to-date

The discontinuation of Beechams Pills marks another loss from the list of older patent medicines – household names that, in their heyday, were the bedrock of OTC sales.

Unfortunately, their advertised promises could never live up to their formulations, and they have inevitably been superseded by modern medicines. I only regret their passing because they invoke memories of less frenetic times when the 'art' of pharmacy was ascendant over its science.

The demise of Beechams Pills was predictable, but SB's passing shot equates well with the extravagant medicinal claims that were previously made for its Pills. SB has not passed to me the professional responsibility for counselling ex-Beechams Pill purchasers but has instead, suggested Milk of Magnesia as an alternative. At least the company has retained its sense of humour!

Education and a fine balancing act

Guest editors to *C&D* always seem to tackle contentious issues, and last week's contribution by Clare Mackie was no exception, with her concentration on accreditation being particularly thought-provoking.

I have no doubt that the only way forward, not only in developing new services, but also in ensuring the quality of those that already exist, is for accreditation to become the lynch pin of continuing education for community pharmacists.

However, for accreditation to be the driving force for continuing education, its benefits need to be equally available to all participating pharmacists. Reward must be commensurate with effort and any expertise must be recognised by guaranteed continuity of service.

I am amazed at the enthusiasm of so many pharmacists for the present continuing education programmes when the perceived benefits of most of these courses are so poor.

The best stimulation to learning must be an awareness that the knowledge will be required, used and rewarded. Accreditation could achieve all these, but if it is introduced as a stick without a carrot, it could end in disastrous disillusion.

Astra's next move?

Astra has, at last, given in to the inevitable and stopped making refills for Pulmicort and Bricanyl inhalers (*C&D* **Medical Matters** May 30). I assume I will now be paid for all complete inhalers by the Prescription Pricing authority, but, as a magnanimous gesture, could Astra not lower the price of its complete inhalers to match that of the now discontinued refills?

Aquaform dressing

Aquaform is a new viscous hydrogel wound dressing which offers good adherence, ease of application and good fluid absorption. Aquaform comes as 15g single use sterile tubes (basic NHS price, £1.74).
Four Pharmaceuticals Ltd. Tel: 01438 821485.

Travel health focus

The British Travel Health Association was launched with the aim of bringing a multidisciplinary approach to travel health, and to provide national support for professionals involved in giving information and advice to the travellers. Its first scientific conference is planned to take place in London on November 7. Anyone interested in becoming a member should write to Fritha Minter, BTHA Secretariat, 4 Bedford Square, London WC1B 3RA. Annual membership costs £20.

Aurum additions

Aurum Pharmaceuticals has launched Ephedrine Hydrochloride Injection 3mg/ml in a 10ml pre-filled syringe (basic NHS price £4.50) and Midazolam Injection 1mg/ml in 50ml vials (basic NHS price £6.00). Both products will be distributed by Distiphar UK.
Distriphar (UK). Tel: 01895 837779.

Somatuline LA

A single 30mg intramuscular injection of Somatuline LA (lanreotide acetate), indicated for the treatment of acromegaly, produces rapid control of growth hormone secretion which is maintained for up to 14 days. Lanreotide is a long acting somatostatin analogue which is an advance on the three times daily octreotide preparations currently in use. Side effects include GI disorders and pain at the site of injection. A single vial costs £350.
Ipsen Ltd. Tel: 01628 771417.

Exelon for Alzheimer's

Exelon (rivastigmine) is an anti-cholinesterase inhibitor, developed by Novartis, which can delay the progression of the symptoms of Alzheimer's disease.

It enables acetylcholine, which is reduced in Alzheimer's patients, to persist for longer at the nerve synapses. It selectively targets the anticholinesterase enzyme in the hippocampus and cortex, which are involved in memory and learning, thought to be the areas of the brain most affected by the disease.

Worldwide trials in about 3,300 patients with mild to moderate Alzheimer's disease showed that, over six months, the drug was significantly better than placebo in preventing further deterioration in mental ability, memory and capacity to perform normal tasks of daily life. In those taking 6-12mg a day there were significant improvements in cognition in 25 per cent, in activities of daily living in 30 per cent and in global rating (a composite measure of cognition, behaviour and functioning) in 32 per cent.

Unlike some previous trials for Alzheimer's treatments, the Exelon ADENA programme included people over 80 and those with a wide range of other diseases for which they were already taking medication. Some people have experienced benefit for up to four years.

The greatest benefits are seen if patients are maintained on their maximum well-tolerated dose, between 3 and 6mg twice daily, taken with food. The recommended starting dose is 1.5mg twice daily, increasing by 1.5mg twice daily at minimum two weekly intervals if well-tolerated, to a maximum of 6mg twice daily. Novartis recommends that prescribing is initiated by hospital specialists with experience in Alzheimer's disease, although GPs may continue supplies.

The most common side effects are nausea, vomiting, anorexia and dizziness. Exelon is contra-indicated in severe liver impairment and should be used with care in conduction defects, gastric or duodenal ulcers, asthma or obstructive pulmonary disease, and those predisposed to urinary obstruction and seizures. It is minimally metabolised by the liver, so has a low risk of interactions. It should not be taken with cholinomimetic drugs and may interfere with anti-cholinergic medications.

Treatment costs $2.25 a day or $821.25 a year, regardless of the strength of capsules. Exelon is available in packs of 28 (1.5mg, 3mg, 4.5mg, 6mg rivastigmine, all $31.50 basic NHS) and 56 capsules (1.5mg, 3mg, 4.5mg and 6mg all $63 basic NHS).

As yet there have been no trials to see if patients unresponsive or intolerant to Aricept would respond to Exelon. Until comparative trials are carried out, the message is that anti-cholinesterase inhibitors as a class are effective in certain patients.
Novartis Pharmaceuticals (UK) Ltd. Tel: 01276 692255.

MEDICAL MATTERS

Warning over inhaled corticosteroids

Inhaled and nasal corticosteroids at prolonged, high dose therapy can lead to systemic adverse effects, such as osteoporosis, warns the latest *Current Problems in Pharmacovigilance*.

The risks of intranasal formulations are generally lower than with inhaled steroids but this is because higher doses are involved. However, they both carry less risk than systemic corticosteroids.

Nevertheless, the Committee on Safety of Medicines and the Medicines Control Agency have come up with the following recommendations on their use:

- dose should be titrated to the lowest dose needed for effective control of asthma or rhinitis
- greater potency corticosteroids does not necessarily mean greater efficacy
- children on prolonged treatment need to have their height measured regularly; where growth has slowed, the dose should be reduced to the lowest necessary to control asthma or rhinitis.

The newsletter also makes recommendations on withdrawal of systemic corticosteroids. The key points include:

- treatment should be for the shortest length of time necessary and at the lowest dose necessary
- taking corticosteroid tablets in the morning and/or on alternate days may reduce adrenal suppression.

Allergy and attractiveness

Allergy symptoms are twice as likely to make women feel unattractive compared to men, according to a new report on the psychological effects of allergies.

The 'Living with Allergy' report from Warner Lambert found 21 per cent of women with allergy symptoms felt unattractive compared to 12 per cent of men. Otherwise, symptomatic men and women were equally irritable (37 per cent), miserable (29 per cent) and unsociable (18 per cent).

"There is a marked gender difference in the number of individuals who believe their allergies make them unattractive. It suggests allergies may be a source of increased distress for women," says Dr Mark Salter, a consultant psychiatrist at St Bartholomew's Hospital.

Allergies cause psychological problems in 60 per cent of the one in two allergy sufferers in the UK. The survey of 1,000 adults also reveals 15 per cent of sufferers reported their allergy had affected their work and 18 per cent avoided going outdoors in spring and summer.

NOS launches first National Osteoporosis month

The National Osteoporosis Society launched its first ever National Osteoporosis month on Monday to urge people of all ages to contact the charity for advice on preventing and treating the disease.

On June 10, the first European report on osteoporosis is being released in Brussels, while on June 25, health minister Tessa Jowell will speak to 700 researchers from 30 countries at the NOS conference.

NOS director, Linda Edwards, says: "Through National Osteoporosis Month, we hope to encourage people [to learn] it's never too early or too late to protect your bones from osteoporosis. It's vital people know who is at highest risk and how diet, exercise, HRT and other treatments can help prevent the disease".

Throughout June, Boots will be raising money for NOS with the sale of badges in its stores.

You like them so much we're extending the offer!

NEW OFFER ENDS 30th SEPTEMBER 1998

Our ONE TOUCH® meters have been selling like hot cakes in pharmacies throughout the UK! And for every meter sold we have reimbursed the lucky pharmacy £20!

As you like the meters (and the £20 notes!) so much, we are extending the offer.

Our specialist national sales team continue to visit diabetes clinics in both hospitals and general practice, demonstrating the meters, explaining the offer and explaining where it is available...that can mean your pharmacy, if you participate!

Phone now for a new supply of vouchers or for further information about how to participate. You'll like the result!

LifeScan Customer Care Freephone:
0800 121200

LIFESCAN
a Johnson & Johnson company

® Registered Trademark

98-066

COUNTERpoints

Höfels hearty garlic tablets

Seven Seas is launching high strength Cardiomax tablets in its Höfels range of garlic oil products.

Enteric-coated for maximum odour control, each one-a-day tablet contains the equivalent of 4g of fresh garlic, conforming to the German medical monograph for products claiming to help maintain a healthy heart and circulation.

The tablets are available in two sizes – 30s (rsp £3.25) and 90s (rsp £7.59).

● Höfels has introduced a new compact 30s size for all the products in its capsule and tablet range.

The move allows four products to be displayed on shelf in the space which previously would have been taken up by three.

Seven Seas Ltd. Tel: 01482 375234.

Allergy brands are on the move

Warner-Lambert Consumer Healthcare is supporting Benadryl Allergy Relief and Beconase Allergy with a motorised window display unit during the hay fever season.

Featuring the strapline 'Unbeatable Allergy Relief', the unit has an eye-catching stop-watch graphic which illustrates Benadryl's 15 minute onset of action. A rotating section shows common allergens as seen in this season's TV advertising for Benadryl.

A complementary compact counter unit is available to display both brands together.

● The company is also running a competition offering pharmacy staff the chance to win an electronic personal organiser by designing a window display on the theme of year-round allergies and their specific allergens.

Warner-Lambert Consumer Healthcare. Tel: 01703 641400.

Solarcaine cools down with new summer formulation

Solarcaine now comes in a cooling gel formulation in addition to the existing cream, lotion and aerosol variants.

Solarcaine Gel (135g, £4.49) contains aloe vera and lignocaine 0.5 per cent to help soothe irritation caused by sunburn, cuts and insect bites.

The gel comes in a portable plastic flip top bottle and, once it has been applied, leaves no sticky residue on the skin.

Schering-Plough Ltd. Tel: 01707 363636.

Bayer scores with Alka-Seltzer XS

Bayer is launching a series of World Cup marketing initiatives for Alka-Seltzer XS.

In-store promotional material for pharmacies includes showcards and shelf edgers to encourage purchase with the slogan 'Feeling foul?'

A radio advertising campaign will be aired on the Chris Evans Breakfast Show on Virgin Radio as well as on Clyde FM and Forth FM in Scotland.

The commercials feature two football fans in the pub suffering from the excesses of the night before. The strapline is: 'Football, it's a game of two halves – but when it's been more than that turn to new Alka-Seltzer XS'.

The company has also produced two million specially branded beer mats which will feature in 2,000 pubs across the country throughout the World Cup.

The mats carry the slogan 'The next important goal is recovering from the night before' and 'Last night went into extra time' above a picture of Alka-Seltzer XS.

Bayer plc Consumer Care. Tel: 01635 563000.

Diocalm summer holiday campaign

Seton Healthcare is supporting its Diocalm diarrhoea remedy with a £500,000 advertising campaign this summer.

Designed to raise consumer awareness of the perils of holiday diarrhoea, the advertising focuses on the fast treatment available with Diocalm Ultra.

It is timed to coincide with the key summer holiday months and target pre-planned purchases.

The campaign includes advertising on national radio and in women's magazines throughout July and August.

Seton Healthcare Group plc. Tel: 0161 654 3000.

The inside story from Seven Seas

Seven Seas is supporting its One-A-Day cod liver oil capsules with a £1 million advertising campaign.

Full colour advertising is appearing in glossy women's magazines carrying the message: 'For health on the inside that shows on the outside'.

Using photography more usually associated with fashion and cosmetic advertising, the campaign focuses on youthful good looks and vitality.

The advertising features the new high absorption Odour controlled Blend One-A-Day 1,000mg capsules as well as the One-a-Day range.

Seven Seas Ltd. Tel: 01482 375234.

Sanatogen strength to vitamin E

Sanatogen plans to introduce a high strength vitamin E supplement in July.

Sanatogen High Strength Vitamin E (30 capsules, £5.99) contains 500mg of the vitamin, the highest amount included in any major brand supplement, according to Roche Consumer Health.

The focus on high strength vitamin E follows studies showing benefits in protecting the heart.

The vitamin E supplement market is currently worth £9.8 million representing 3.1 per cent of the total vitamin/mineral supplement market.

Roche Consumer Health. Tel: 01707 366000.

The new treatment for the terrible twos

Dehydration and Diarrhoea

NEW

New Dioralyte Relief, the first and only rice-based oral rehydration therapy, is now being promoted to GP's and advertised direct to consumers. Clinical evaluation has shown rice ORT to be more effective than traditional glucose-based ORT, in promoting fluid absorption.[1] In addition, recovery time is reduced, as well as the duration of diarrhoea.[2] Which is a relief all round because a prompt recovery puts an early end to everyone's distress. In-store point-of-sale materials are now available on request, to help you make the most of this new sales opportunity. Prescriptions and requests are building – so stock up. There is after all, no real alternative.

Dioralyte relief

Rice powder, potassium chloride, sodium chloride, sodium citrate

Diarrhoea relief with rapid rehydration

ABBREVIATED PRESCRIBING INFORMATION **Presentation:** Sachet containing active ingredients pre-cooked rice powder 6g, sodium citrate EP 580mg, sodium chloride EP 350mg, potassium chloride EP 300mg as powder for reconstitution with water. **Indications:** Oral correction of fluid and electrolyte loss and treatment of watery diarrhoea of various aetiologies including gastro-enteritis in all age groups from 3 months upwards. Particularly recommended in case of too loose or frequent stools where it enables over loose stools to revert to normal. **Administration and Dosage:** Each sachet should be reconstituted in 200ml fresh drinking water. For infants or where drinking water is not available the water should be freshly boiled and cooled. Adults and children over 1 year - One sachet after each loose motion up to 5 sachets per day for 3-4 days, Infants 3 months to 1 year under medical supervision - 150 to 200 ml/kg/24 hours, half the volume to be given during first 8 hours and other half during next 16 hours. Under 3 months not recommended. **Contra-Indications:** Patients with phenylketonuria, intestinal obstruction, severe renal and hepatic impairment. **Special Warnings and Precautions:** Do not dissolve in a diluent other than water. If diarrhoea persists unremittingly for longer than 36 hours the patient should be reassessed by the physician. Care in cases of renal and hepatic impairment or where electrolyte balance disturbed. May be used in pregnancy and lactation under medical advice. **Interactions and Undesirable Effects:** None Known. **Basic NHS Price:** 20 sachets £5.63. Retail Selling Price 6 sachets £3.40. **Legal Category P PL 00012/0275. Product Licence Holder and further information** from Rhone Poulenc Rorer, Kings Hill, West Malling, Kent, ME19 4AH. **References:** **1.** Pizarro D et al. New Eng J Med 1991; 324:517-521. **2.** Wall CR et al. J Gastroenterol and Hepatol 1997; **12**:24-28. Date of preparation: March 1998. OTC 20028

RHÔNE-POULENC RORER

Cussons improves liquid assets

Cussons is relaunching its Carex Antibacterial handwash and introducing a new variant.

Carex Antibacterial is now formulated with Dermaclens – a moisturising system with antibacterial action derived from natural oils.

In addition to cleansing the skin thoroughly to remove germs, it is designed to be kinder to skin than the original product.

Carex Hypo-allergenic is a new variant which is formulated to thoroughly remove germs, dirt and odours from the most sensitive skin, leaving hands feeling soft and smooth.

Retail prices are £1.79 for Carex Antibacterial (250ml), £1.99 for Carex Hypo-allergenic (250ml).

Cussons (UK) Ltd.
Tel: 0161 491 8000.

Almay's One Coat colour cuts time

Revlon will be launching a One Coat Collection of nail colours in its Almay range on July 8.

One Coat Nail Colour is designed to be applied with one fast-drying, conditioning coat which sets in 90 seconds.

Available in 16 shades, the range includes three colourways – nudetones, blushtones and plumtones.

The products contain vitamin derivatives A, E and biotin. Retail price is £4.95.

● The nail products will join three One Coat eye products – Gel Eyecolour, Gel Eye Pencil and Mascara, launched in May.

Revlon International Corp.
Tel: 0171 629 7400.

Hair today, gone tomorrow

Mariana Bodycare Products has reformulated its Mariana hair removal creams.

Mariana Hair Remover Cream and Facial Cream are now formulated to work quicker, taking only four minutes.

Both products include a new hair regrowth inhibitor, which weakens and retards the growth cycle of any new regrowth.

According to the company, the results of hair regrowth reduction can be up to 20 per cent.

The products contain extracts of aloe vera and natural oils to prevent the skin from drying.

Retail prices are £3.25 for Hair Removal Cream and £3.75 for Facial Hair Remover Cream.

Ceuta Healthcare Ltd.
Tel: 01202 780558.

Elvive's new technology for brittle and damaged hair

L'Oréal will be introducing new technology into its Elvive hair care range in August.

The company's new Nutri-Ceramide complex has been developed specifically for hair which has become brittle and damaged.

The complex contains Ceramide R, a duplicate of the hair's natural strengthener – ceramide.

The Elvive Nutri-Ceramide range includes Revitalising Shampoo, Revitalising Conditioner, Revitalising Conditioner Non-Rinse Mousse, Daily Repair Concentrate and Deep Repair Conditioner.

Retail prices range from £1.29 to £4.99.

L'Oréal.
Tel: 0171 937 5454.

Join the Jet-Set with L'Oréal

L'Oréal will be launching a new range of fast drying nail varnishes in August.

The L'Oréal Jet-Set range is formulated with a new resistant resin which dries in one minute.

The product also includes polymers to give a high gloss shine so there is no need for a top coat.

The range comprises 15 colours (rsp £4.99).

L'Oréal.
Tel: 0171 937 5454.

Mix 'n' match colours to design your own fingertips

Grafton International has introduced a US range of nail polishes in the UK.

Called Ripe, the collection features 68 colours including glitters, metallics, frosts and deep dark colours.

The idea behind the range is for consumers to create their own colours by painting one polish on top of another.

Single or mixed glitters can be applied on top of a solid colour for a sparkling three colour-way result.

Retail price is £9.50.

Grafton International.
Tel: 01543 480100.

Staying power for Miners lipsticks

Miners Cosmetics has launched a new lipstick collection.

Eternal Lip Colour features 12 long-lasting colours including 'Spend a Lifetime' (natural nude), Something to Save (deep burgundy) and Staying Alive (pearly brown).

Presented in an elegant black and gold case, the products retail at £3.49.

Paul Murray plc.
Tel: 01703 268444.

All-in-one hair removal gel

Carter-Wallace is launching a new all-in-one hair removal and skin care product in its Nair range.

Nair 3 in 1 Gel combines moisturising particles with a cool gel to help leave skin soft and in top condition after hair removal.

Gold and white particles contain allantoin and vitamin E, while aloe and NMF (Natural Moisturising Factor) enrich the gel.

The product retails at £4.49 (150ml).

Carter Wallace Ltd.
Tel: 01303 850661.

ON TV NEXT WEEK

Bazuka: GTV, U, STV, A, HTV, M, Sat

Benadryl Allergy Relief: All areas

Canderel: C, LWT, CAR

Daktarin: All areas except GTV, U, STV, CTV, GMTV

Gaviscon Advance: All areas

Imodium Plus: All areas

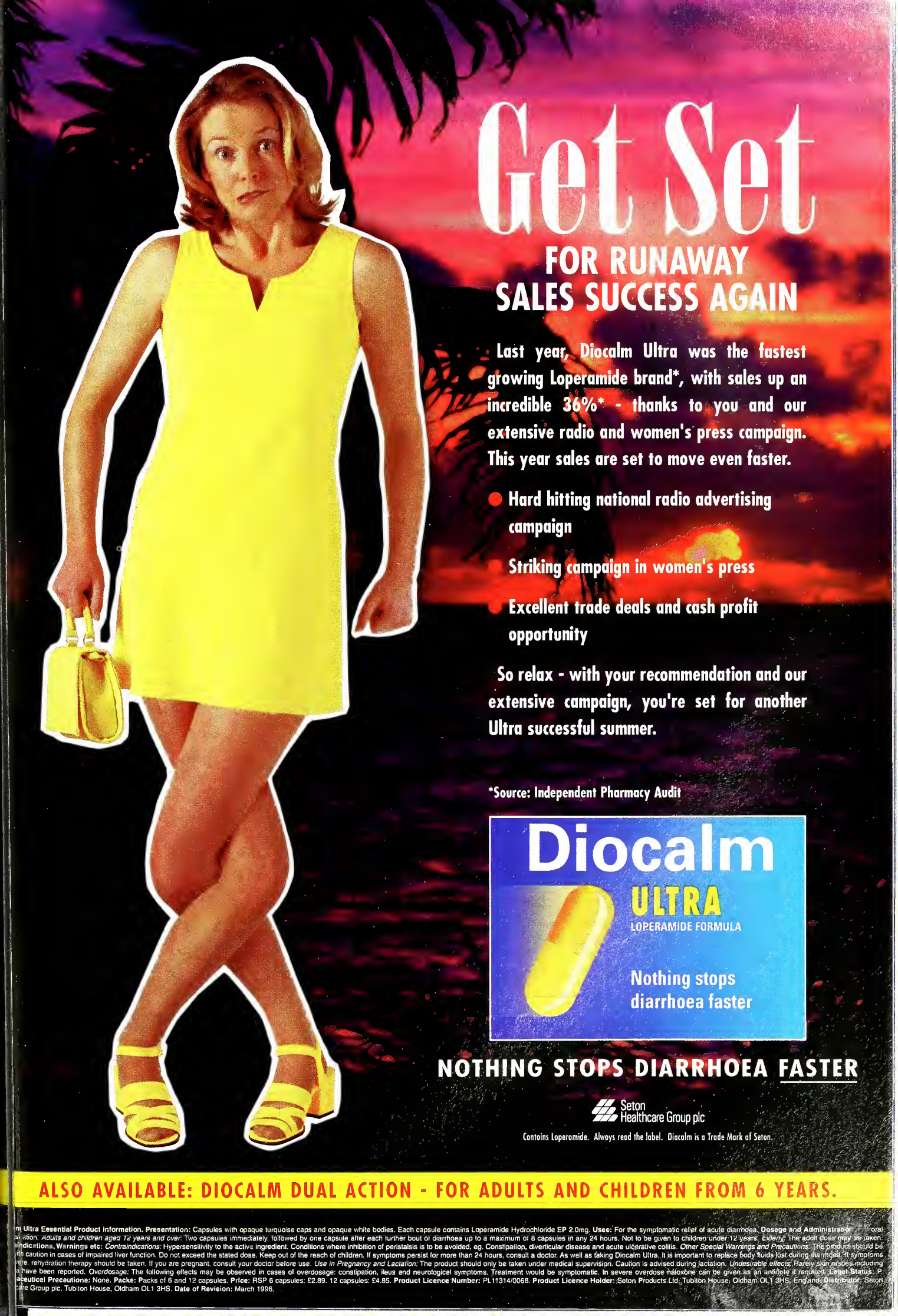
Kodak Advantix: All areas

Listerine antiseptic mouthwash: GTV, STV, G, A, M, ITV

Slim Fast: All areas

Wella Shock Waves: Sat

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TSW** TV South West, **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire



m Ultra Essential Product Information. Presentation: Capsules with opaque turquoise caps and opaque white bodies. Each capsule contains Loperamide Hydrochloride EP 2.0mg. **Usee:** For the symptomatic relief of acute diarrhoea. **Dosage and Administration:** For oral ...ration. *Adults and children aged 12 years and over:* Two capsules immediately, followed by one capsule after each further bout of diarrhoea up to a maximum of 8 capsules in any 24 hours. Not to be given to children under 12 years. *Elderly:* the adult dose may be taken. **...indications, Warnings etc:** *Contraindications:* Hypersensitivity to the active ingredient. Conditions where inhibition of peristalsis is to be avoided, eg. Constipation, diverticular disease and acute ulcerative colitis. *Other Special Warnings and Precautions:* The product should be ...th caution in cases of impaired liver function. Do not exceed the stated dose. Keep out of the reach of children. If symptoms persist for more than 24 hours, consult a doctor. As well as taking Diocalm Ultra, it is important to replace body fluids lost during diarrhoea. If symptoms ...ere, rehydration therapy should be taken. If you are pregnant, consult your doctor before use. *Use in Pregnancy and Lactation:* The product should only be taken under medical supervision. Caution is advised during lactation. *Undesirable effects:* Rarely skin rashes including ...s have been reported. *Overdosage:* The following effects may be observed in cases of overdosage: constipation, ileus and neurological symptoms. Treatment would be symptomatic. In severe overdose naloxone can be given as an antidote if required. **Legal Status:** P **...aceutical Precautions:** None. **Packs:** Packs of 6 and 12 capsules. **Price:** RSP 6 capsules: £2.89. 12 capsules: £4.85. **Product Licence Number:** PL11314/0068. **Product Licence Holder:** Seton Products Ltd, Tubiton House, Oldham OL1 3HS, England. **Distributor:** Seton ...care Group plc, Tubiton House, Oldham OL1 3HS. **Date of Revision:** March 1996.

Sensodyne toothbrushes bloom

Stafford-Miller is launching a range of toothbrushes with floral designs in its Sensodyne range.

Sensodyne Florals is targeted at teenagers and young adults in an attempt to widen the appeal of the printed toothbrush market.

The toothbrushes have been developed using two-sided printing on clear handles to produce an eye-catching 3D effect.

The range comes in a choice of three bold, floral designs.

Retail price is £1.99.

Stafford-Miller Ltd.
Tel: 01707 331001.

Holiday campaign

Novartis is supporting its Ex-Lax Senna laxative with a £500,000 ad campaign this summer. With holidaymakers being frequent sufferers from constipation, the campaign will run from July to September in the national press and women's magazines.

Novartis Consumer Health.
Tel: 01403 210211.

Making faces

Procter & Gamble will be offering a special £1.50 price reduction on any shade of its Max Factor 3-in-1 Complete Make-up during September and October. Launched at the start of this year, it is now the best-selling Max Factor product (normal rsp £9.50).

Procter & Gamble (Health Beauty & Cosmetics) Ltd.
Tel: 01932 896000.

Calling at all stations to Blond Street underground

To celebrate the launch of Hydrience Absolute Blondes, the new collection of permanent high-lift blonde hair colorant shades, Clairol is transforming Bond Street underground station in London into Blond Street.

Over half a million people passing through 'Blond' Street during June will see dozens of sites within the station complex from platform posters to display units. In addition, 60 London buses in the Blond Street area will feature a continuation of the Hydrience Absolute Blondes poster campaign.

The month-long promotion was officially opened on June 1 by four blonde models from the Select model agency.

On Saturday June 6 a team of beauty experts will be scouting the Blond Street area for new beautiful, blonde models. The winner of the competition may have a chance of securing a contract with one of London's top model agencies.

Other activities at the station during the week include Clairol's personalised hair colour consultations and the opportunity to take part in a survey to discover if it's true that blondes really do have more fun.

Bristol-Myers Co Ltd Haircare & Toiletries Division.
Tel: 01895 628000.

S&G on the ball with star search

Colgate-Palmolive is launching a star search competition sponsored by its Soft & Gentle anti-perspirant deodorant which is targeted at 16-24-year-olds.

The 1998 Soft & Gentle Music Search is being run in conjunction with recording giant EMI.

Would-be stars around the country are being invited to send in a demo tape of original work or a cover song.

At the end of July, a panel of judges, including TV and radio personality Zoe Ball, will select the winners who will have the chance to record their song at the Abbey Road studios.

The track will then be released on a CD which will feature in Soft & Gentle promotional activity.

Colgate-Palmolive Ltd.
Tel: 01483 302222.

In the picture

Kodak will stop manufacturing its Kodak Gold 126 film, designed for exclusive use in 126 cameras, from December 31, 1999. The move is to encourage 126 users to move onto other Kodak products which it says give better pictures.

Kodak Ltd.
Tel: 01442 61122.

Longer memories

Fuji Photo Film is launching a new photographic paper – Fujicolor Crystal Archive – to provide prints which last longer with minimal fading. The launch will be supported by a £500,000 ad campaign featuring a 'fading girl'.

Fuji Photo Film (UK) Ltd.
Tel: 0171 586 5900.

Sensational blitz

Colgate-Palmolive is supporting its Colgate Sensation Deep Clean toothpaste and toothbrush range with a national summer television and illuminated poster advertising blitz.

Colgate-Palmolive (UK) Ltd.
Tel: 01483 302222.

Nothing reduces fever further...

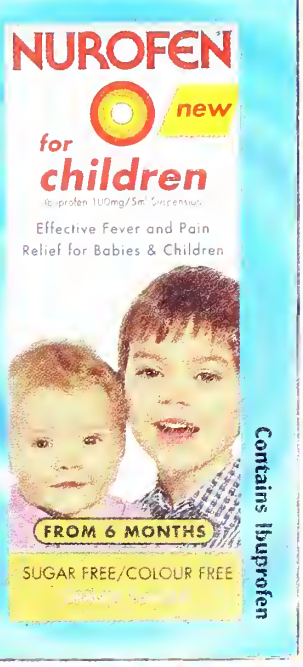
acts faster...

or lasts longer**

New Nurofen for Children contains Ibuprofen which works fast on fevers, acting within 30 minutes[1,2] and lasting for up to 8 hours.[1-4]

Nurafen for Children is a new formulation of Junifen and offers fast, effective pain and fever relief.[1,4,6] Pleasantly orange-flavoured and with Nurafen's reassuring safety profile,[7,8] it is suitable for a range of indicatians in babies and children from 6 months upwards.[9] Sound reasans ta recommend Nurafen far Children.

new



The logical choice

PRODUCT INFORMATION: NUROFEN FOR CHILDREN. Oral suspension containing: ibuprofen 100mg/5ml **Also contains:** Citric acid, Sodium Citrate, Sodium Chloride, Sodium saccharin, Domiphen bromide, Purified water, Polysorbate 80, Maltitol syrup, Xanthan gum, Orange flavour, Glycerine **Indications:** Prescription only – For symptomatic treatment of Juvenile Rheumatoid Arthritis **Prescription and DTC:** For the fast and effective reduction of fever, including post immunisation pyrexia and the fast and effective relief of mild to moderate pain, such as sore throat, teething pain, toothache, earache, headache, minor aches and sprains **Dosage:** For pain and fever The daily dosage of Nurofen for Children is 20-30 mg/kg body weight in divided doses This can be achieved as follows Infants 6-12 months: One 2.5 ml spoonful may be taken 3 times in 24 hours Children 1-2 years: One 2.5 ml spoonful may be taken 3 to 4 times in 24 hours Children 3-7 years One 5 ml spoonful may be taken 3 to 4 times in 24 hours Children 8-12 years Two 5 ml spoonfuls may be taken 3 to 4 times in 24 hours Not suitable for children under 6 months of age unless advised by your doctor For Juvenile Rheumatoid Arthritis The usual daily dosage is 30 to 40 mg/kg/day in three to four divided doses For post immunisation pyrexia One 2.5 ml spoonful followed by one further 2.5 ml spoonful 6 hours later if necessary No more than two 2.5 ml spoonfuls in 24 hours If the fever is not reduced, consult your doctor For oral administration For short term use only **Precautions and Warnings:** If symptoms persist for more than three days, consult your doctor Do not exceed the stated dose Caution is required in patients with renal, cardiac or hepatic impairment Asthma sufferers, anyone allergic to aspirin, receiving any other regular treatment and pregnant women should consult their doctor before taking Nurofen for Children Nurofen for Children is not suitable for patients who have a stomach ulcer or other stomach disorder Not recommended for children under 6 months unless advised by a doctor **Side effects:** Rare but may include abdominal pain, nausea, dyspepsia and gastrointestinal bleeding and peptic ulceration Also rashes, and very rarely thrombocytopenia have been reported Bronchospasm may be precipitated in patients with a history of aspirin sensitive asthma **Product Licence Number.** PL 00327/0085 **Licence Holder and Manufacturer.** Crookes Healthcare Limited NG2 3AA **Legal Category:** POM and P **Price:** £3.05 **Date:** March 1998 **References.** 1 Walson PD, Galletta G, Braden NJ *et al* Clin Pharmacol Ther 1989, **46**: 9-17 2 Sidler J, Frey B, Baerlocher K Br J Clin Pract 1990, **44** (Suppl 70): 22-5 3 Kauffmann RE, Sawyer LA and Schenbaum ML AJDC 1992, **146**: 622-5 4 Nahata MC, Powell DA, Durrell DE Int J Clin Pharmacol Ther Toxicol 1992, **30** (3): 94-96 5 Schachtel BP, Thoden WR Pediatr Res **29** (4 part 2) 1991, 124a 6 Bertin L, Pons G, Duhamel JF *et al* Fundam Clin Pharmacol 1991, **5** (5): 409 7 Lesko SM and Mitchell AA JAMA 1995, **273** (12): 929-33 8 McIntyre J and Hull D Arch Dis Childhood 1996, **74**: 164-7 9 Nurofen for Children summary of Product Characteristics *than ibuprofen

CROOKES HEALTHCARE

ADVANCE WARNING

£

£

£

£

This is an advance whether warning for Saturday 6th June

Whether you are ready or not, all areas across the country will experience strong sales force wins due to a new front caused by high pressure, as national TV exposure of Gaviscon Advance begins.

Previous TV exposure of Gaviscon created wide spread outbreaks of sunny smiles and a deluge of re-orders for more product. So, make the most of the strongest advance ever to the No1 pharmacy only heartburn brand, Gaviscon Advance.

But be warned, those particularly well stocked areas with prominent point of sale risk possible floods.

GAVISCON ADVANCE

sodium alginate BP, potassium bicarbonate USP

Advanced formula for heartburn

Gaviscon Advance Essential Information

Gaviscon Advance Active Ingredients: Sodium alginate BP 1000mg and potassium bicarbonate USP 200mg per 10ml dose. Also contains ethyl and sodium butyl hydroxybenzoates and sodium saccharin. **Indications:** Gastric reflux, reflux oesophagitis, heartburn, hiatus hernia, flatulence associated with gastric reflux, heartburn of pregnancy. All cases of epigastric and retrosternal distress where the underlying cause is gastric reflux. **Dosage instructions:** Adults and children over 12: 5-10ml after meals and at bedtime. Children under 12: Only on medical advice. **Contra-indications:** Hypersensitivity to any of the ingredients. **Precautions and warnings:** 10ml liquid contains 4.6mmol (106mg) sodium and 2.0mmol (78mg) potassium. If symptoms do not improve after seven days, the doctor should be consulted. **Side-effects:** Very rare hypersensitivity reactions. **Retail price:** 140ml £3.90.

Marketing Authorisation: 0063/0097. **Su Classification:** Pharmacy Medicinal Product. **Holde Marketing Authorisations:** Reckitt & Colman Prod Limited, Dansom Lane, Hull HU8 7DS. Gaviscon Advance the sword and circle symbol are trademarks. Dat preparation: May 1998.

Reckitt & Colman Products Limited

PHARMACY update

When stroke strikes

Stroke is the third biggest killer and the leading cause of physical disability in the UK. Adrienne de Mont outlines current thinking on prevention and treatment

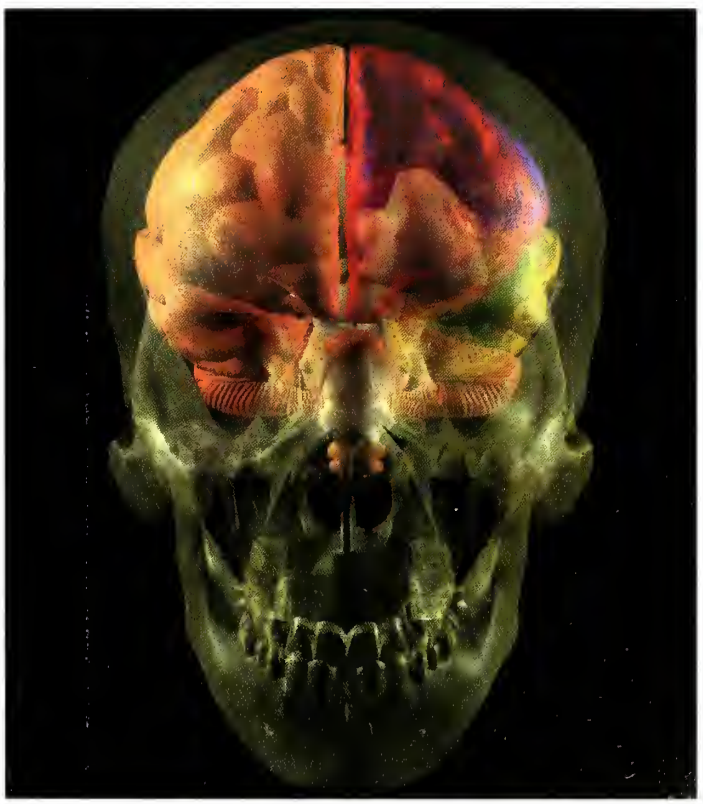
THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1092), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JULY 11, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To recognise the different types of stroke
- To be aware of risk factors that could lead to stroke
- To be familiar with first aid procedures in suspected stoke
- To be familiar with drug and non-drug management of stroke
- To recognise the importance of rehabilitation

Every year about 100,000 people in the UK have a stroke for the first time. Although the risk increases with age and strokes are rare under the age of 40, not all sufferers are elderly – about one-tenth are under retirement age.



Brain cell damage occurs when blood supply is disrupted

Pathophysiology

A stroke disrupts the blood supply to the brain, depriving the cells of oxygen and other nutrients. Some cells die and others are damaged. If the patient survives, the degree of disability depends on the area of the brain affected. As damaged cells recover, the patient may gradually improve, but brain tissue that has died is gone forever.

Most strokes (about 80 per cent) occur when a blood clot blocks an artery carrying blood to the brain (ischaemic stroke). This may be either a cerebral thrombosis, when a clot forms at the site of the blockage, or a cerebral embolism, when the clot forms elsewhere in the body and travels to the brain. In the latter, the embolus may start in the heart after a heart attack or as a result of irregular heart rhythm or heart valve problems.

Lacunar stroke happens when small blood vessels deep in the brain become blocked over the long term.

About one-sixth of strokes are caused by blood leaking from a damaged blood vessel (haemorrhagic stroke); the haemorrhage is described as intracerebral if it is within the brain and subarachnoid if the bleeding is into the space surrounding the brain.

Typical symptoms of stroke are numbness, weakness or paralysis down one side of the body and difficulty with swallowing, speaking, reading and writing. Other symptoms are disturbed vision, incontinence, headache, tiredness and confusion. A stroke in the right side of the brain affects the left side of the body and vice versa.

Cerebral oedema, a serious complication occurring in the days immediately afterwards, can cause swelling of the brain tissue and increased intracranial pressure leading to further damage to blood vessels and bleeding.

A transient ischaemic attack (TIA) or 'mini-stroke' occurs when a blood clot temporarily blocks an artery. Again there is weakness or numbness in an arm, leg or one side of the face or body, possibly with disturbances of vision and speech. But the symptoms disappear quickly – sometimes in a few minutes and always within 24 hours. It is, however, an important warning that the person is at risk of a major stroke. About 7 per cent of patients have a stroke within a year of a TIA.

Someone who has already had a stroke is four times more likely to have another than someone who has not. Stroke victims are also more likely to have a heart attack.

While strokes were once dismissed as an inevitable hazard of ageing, there is growing acceptance that the risks can be greatly reduced with lifestyle changes or preventive medication.

Risk factors

Several factors are known to increase the risk of stroke:

- **High blood pressure**

Hypertension is the most common cause of stroke. People with high blood pressure are up to seven times more at risk than those with low blood pressure. As well as contributing to atherosclerosis, hypertension puts a strain on the arterial walls, increasing the risk of bleeding.

- **Smoking**

Smoking is the second most common avoidable cause of stroke. It increases blood pressure and causes atherosclerosis. It makes the blood more likely to clot by increasing fibrinogen levels and platelet aggregation.

- **Heart disease and atherosclerosis**

A history of heart disease more than doubles the chance of stroke and a clot is more likely to block the blood flow if the artery has become narrowed by atherosclerosis.

Continued on PII ▶

First aid in suspected stroke

Arrange for urgent transfer to hospital. If conscious, lay the casualty down with the head and shoulders slightly raised and head turned slightly to the side to allow saliva to drain from the mouth. Loosen tight clothing around the neck, chest and waist. Do not give anything to eat or drink (including aspirin). If the casualty is thirsty, moisten lips with water. Except in an emergency, such as fire risk, avoid pulling on limbs which may be paralysed. If casualty loses consciousness, place in the recovery position. If breathing or heartbeat stops, start cardiopulmonary resuscitation.

Giving up smoking is one of several lifestyle changes to reduce risk

◀ *Continued from P1*

The importance of raised serum cholesterol levels in increasing stroke risk is not well established, so routine use of lipid-lowering agents in stroke survivors is not felt to be justified unless they have coronary artery disease.

- **Atrial fibrillation**

The irregular beat may lead to blood clots forming in the heart, which travel to the brain.

- **Too much alcohol**

Binge drinking increases the risk of stroke five-fold, as it can make the blood pressure soar. Heavy drinking on a regular basis also raises blood pressure.

- **Lack of exercise**

Regular exercise lowers blood pressure, helps weight loss and improves the blood lipid profile.

- **An unhealthy diet**

High salt consumption can cause hypertension, while a diet high in saturated fats can lead to atherosclerosis.

- **Diabetes**

People with diabetes are more prone to hypertension and atherosclerosis.

- **Taking oral contraceptives**

Studies of the earlier high dose pills showed a definite increase in risk. But the WHO Collaborative Study of Cardiovascular Disease and Steroid Hormone Contraception (*The Lancet* 1996, **348**: 498-510) showed that the risk of ischaemic stroke is low. It can be reduced further if women are under 35 years old, do not smoke, have regular blood pressure checks and take low oestrogen doses. For haemorrhagic strokes there is an increased risk in women over 35 and smokers, and the risk increases ten to 15 times in those with a history of hypertension.

- **Racial origin**

People of Asian or Afro-Caribbean origin are more susceptible to strokes

- **Having a close relative with stroke**

Although stroke is not hereditary, risk factors such as hypertension and diabetes tend to run in families.

The Stroke Association warns that risk factors do not just add up, they are multiplied. So a smoker (at twice the risk) who has high blood pressure (seven times the risk) and is physically inactive (twice the risk) has a 28 times (2x7x2) greater risk of stroke than an active non-smoker of the same age who has normal blood pressure.

Lifestyle changes

Advice on lifestyle applies to people at high risk as well as those who have already had a stroke. The following should be encouraged:

- giving up smoking
- exercise
- drinking in moderation
- change to a healthy diet.

Drugs used in prevention

Antihypertensives

The Stroke Association says that, for every ten people who die from strokes, four could have been saved if they had had regular blood pressure checks and then followed medical advice. Doctors usually aim to reduce the systolic pressure to below 160mm/Hg and the diastolic figure to below 90.

Research by the Stroke Association shows that most people who abandon their drug therapy do so because of unacceptable side effects. "Yet for nearly all those individuals there was a drug, which would have suited them, waiting on the pharmacist's shelf," says the leaflet, 'Why you need to take your drugs'. It urges patients not to suffer in silence if they think their medicines are turning them from healthy people into unhealthy ones.

The British Hypertension Society recommends beta-blockers (except in asthma or cardiac failure) or thiazide diuretics (except in diabetes) as first line treatments. Diuretics are favoured for the elderly and beta-blockers in ischaemic heart disease. Calcium channel blockers, angiotensin-converting enzyme (ACE) inhibitors or selective alpha-1 antagonists are recommended where the first choice is ineffective, poorly tolerated or contraindicated.

Aspirin

In patients who have had warning symptoms of a stroke, regular low-dose aspirin can reduce the risk of stroke recurrence by some 20 per cent.

An overview from the Antiplatelet Triallists' Collaboration (*Brit Med J* 1994, **308**: 81-106) showed that, for healthy people with no symptoms of arterial disease, there was no need to take aspirin, but there were definite benefits in high risk patients, such as those who had had previous heart attacks, strokes or TIAs. The study disclosed a few cerebral haemorrhages in 54,000 treated patients, but this did not represent a statistically significant excess risk.

The usual recommended dose is 75mg a day in people who have already suffered a stroke or TIA. Higher doses are no more effective, although up to 300mg may be used in the acute stage of a stroke.

Other anti-platelet drugs

Modified-release dipyridamole offers an alternative in patients intolerant of aspirin.

The European Stroke Prevention Study 2 showed that dipyridamole and aspirin have an additive effect when used together. The study followed over 6,000 patients who had already had a stroke or TIA. A combination of modified release dipyridamole 200mg and aspirin 25mg twice daily reduced the risk of a second stroke by 37 per cent, compared with placebo.

The reduction was 18 per cent with the same amount of aspirin alone and 16 per cent with dipyridamole alone (*J Neurolog Sci* 1996, **143**: 1-13).

Other small-scale trials have shown more modest benefits. Dipyridamole can cause headache and diarrhoea.

Warfarin

Warfarin is a coumarin anticoagulant which inhibits vitamin K, thereby indirectly depressing synthesis of coagulation factors VII, IX and X and prothrombin. As it acts indirectly it has no effect on existing clots, so should not be used in cerebral thrombosis. It can, however, be useful in TIAs, particularly if aspirin treatment has not been successful, and is given as prophylaxis in atrial fibrillation.

The typical induction dose is 10mg for two days, but this should be tailored to individual requirements. The maintenance dose is usually 3-9mg, taken at the same time each day. The maintenance dose depends on prothrombin time, expressed as INR (international normalised ratio), which is monitored regularly (see also *C&D* February 21, pII-V).

The major risk is haemorrhage, resulting in haematomas and anaemia; skin necrosis and purple discoloration of the toes occur occasionally. It should, therefore, not be given to people at serious risk of haemorrhage, such as those with actual or potential haemorrhagic conditions (eg severe hypertension and peptic ulcer).

Patients should report nose bleeds without any apparent cause, black or red faeces and dark red or brown urine to the doctor. They are also advised

Continued on PVI ▶

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LOS ADV 3190

ASTRA

◀ Continued from PII

to report skin rash, hair loss, nausea, vomiting, diarrhoea, fever, jaundice or breathing difficulties. Warfarin is teratogenic.

The main interactions are with anabolic steroids, anti-arrythmics, antibiotics, anti-epileptics, antifungals, aspirin and other non-steroidal anti-inflammatory drugs (NSAIDs), cimetidine, lipid-lowering drugs, omeprazole, oral contraceptives, proguanil, selective serotonin re-uptake inhibitors (SSRIs), sulphinpyrazone, thyroxine (for details see BNF).

The effects of warfarin are enhanced by large amounts of alcohol and may be reduced by increased dietary intake of fats and oils. Vitamin K is present in vegetables, so major changes in diet may also affect control, as may taking the vitamin in supplements.

Investigations in hospital

These are used to confirm diagnosis, as brain tumour and encephalitis can cause similar symptoms. Computed tomography (a CT scan) enables doctors to examine cross-sections of the brain and assess structural changes. It is best carried out in the first 48 hours after the stroke. Magnetic resonance imaging (an MRI scan) provides high quality three-dimensional images and can highlight ischaemic areas more quickly than a CT scan, without using X-rays. Such investigations can differentiate between a stroke caused by infarction and one caused by bleeding.

Acute treatment

Dr Peter Sandercock, reader in neurology, Edinburgh University, believes that admitting the patient to a specialist stroke unit carries more benefit than any drug treatment, both in terms of lives saved and prevention of long-term disability.

"Such units have a structured system that approaches the diagnosis, management and prevention of complications in a co-ordinated, multidisciplinary way," he says. For example, the clinicians would investigate a patient's ability to swallow, in order to prevent aspiration pneumonia, and they might give oxygen to reduce brain damage if the patient had breathing problems.

Dr Sandercock was involved in the International Stroke Trial, which looked at the use of aspirin and heparin in the treatment of acute stroke.

Aspirin

Until recently, aspirin was not given until some weeks after a stroke because of worries that it might cause bleeding. But two recent trials, published in *The Lancet* last year, showed that aspirin is beneficial when given as soon as a scan has identified ischaemic stroke.

In the Chinese Acute Stroke Trial, about 20,000 hospital patients were given 160mg aspirin daily. In the International Stroke Trial 20,000 hospital patients in 36 other countries took 300mg daily. Most patients had CT scans to exclude haemorrhagic stroke. Overall, there were about ten fewer deaths or non-fatal recurrent strokes within 14 days per 1,000 patients treated. After six months there were 13 fewer dead or dependent patients for every 1,000 treated. Patients were also more likely to make a complete recovery (an extra ten per 1,000) if aspirin was given early.

Aspirin was associated with an excess of two haemorrhagic strokes per 1,000 patients treated, so the risk of bleeding was less than the drug's benefit.

Dr Sandercock recommends giving at least 160-300mg a day for the first three days in the acute phase, with 75mg-300mg a day in long-term prophylaxis. Patients who cannot swallow can be given aspirin in a suppository. It is worth adding dipyridamole if TIAs are not adequately controlled, he says, although he would not recommend it routinely for every case.

Heparin

There appears to be no net short-term or long-term benefit of any of the heparin regimens tested in most properly randomised trials, according to Dr Sandercock. Benefits are offset by an increased risk of intracranial bleeding, which is dose-related.

Thrombolytics

Alteplase has been submitted for approval for use in acute stroke in the UK. But Dr Sandercock believes that further evidence of their benefit is needed before the public, GPs, ambulance staff and hospitals are geared up to dealing with stroke patients within a couple of hours, as happens with heart attack victims.

Evidence in favour of rapid treatment with thrombolytics in myocardial infarction was based on trials involving 60,000 patients, while trials in stroke have involved only about 3,500 patients. The problem is that, while stroke patients who survive after thrombolytics are likely to be less disabled, there is a risk of intracranial bleeding even if the CT scan has revealed a non-haemorrhagic stroke. As always, possible benefit must be balanced against the risks.

Dr Sandercock believes larger trials are necessary to clarify which patients are most likely to benefit. It would also help health authorities decide whether it is more cost-effective to put money into developing rapid admission policies or to concentrate on stroke rehabilitation units.

Other drugs

Nimodipine is a calcium channel antagonist which is used to prevent neurological damage following subarachnoid haemorrhage.

Baclofen, dantrolene and diazepam have been used to reduce muscle spasm and pain, although they tend to cause weakness. They play little part in rehabilitation.

Research is being carried out to find drugs that can protect the brain against further damage in the early stages after a stroke or reverse the damage that has already occurred. So far, clinical trials with neuroprotectants have been disappointing. Any benefits have been offset by unacceptable psychiatric side effects, such as hallucinations and confusion.

Surgery

Carotid endarterectomy may be offered to people who have recently had a TIA or mild stroke and who have severe narrowing of the internal carotid artery in the neck. This narrowing can be detected by a Doppler or Duplex ultrasound test or an angiogram.

The operation involves removing areas of atherosclerosis where blood clots are likely to form. If successful it can almost abolish the risk of stroke over the next two or three years, although there is a small risk of stroke occurring a day or so after surgery.

Rehabilitation

Symptoms often improve most rapidly in the weeks immediately following the stroke, as some of the damaged area surrounding the dead cells recovers. Improvement over later months is more gradual, with the most progress generally taking place in the first 18 months. Those likely to make a good recovery tend to do so in the first three months.

Rehabilitation aims to help stroke sufferers regain as much independence as possible. Physiotherapists advise on suitable exercises to restore mobility, while occupational therapists help patients to find ways of managing everyday activities such as washing and dressing. Speech and language therapists can help with difficulties in communication. District nurses, too, may assist with home care and rehabilitation. All can be contacted via a GP.

Details of other sources of help are in the Stroke Association's free booklet, 'After your stroke: a first guide' (see **Resources** box, below).

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2000.*

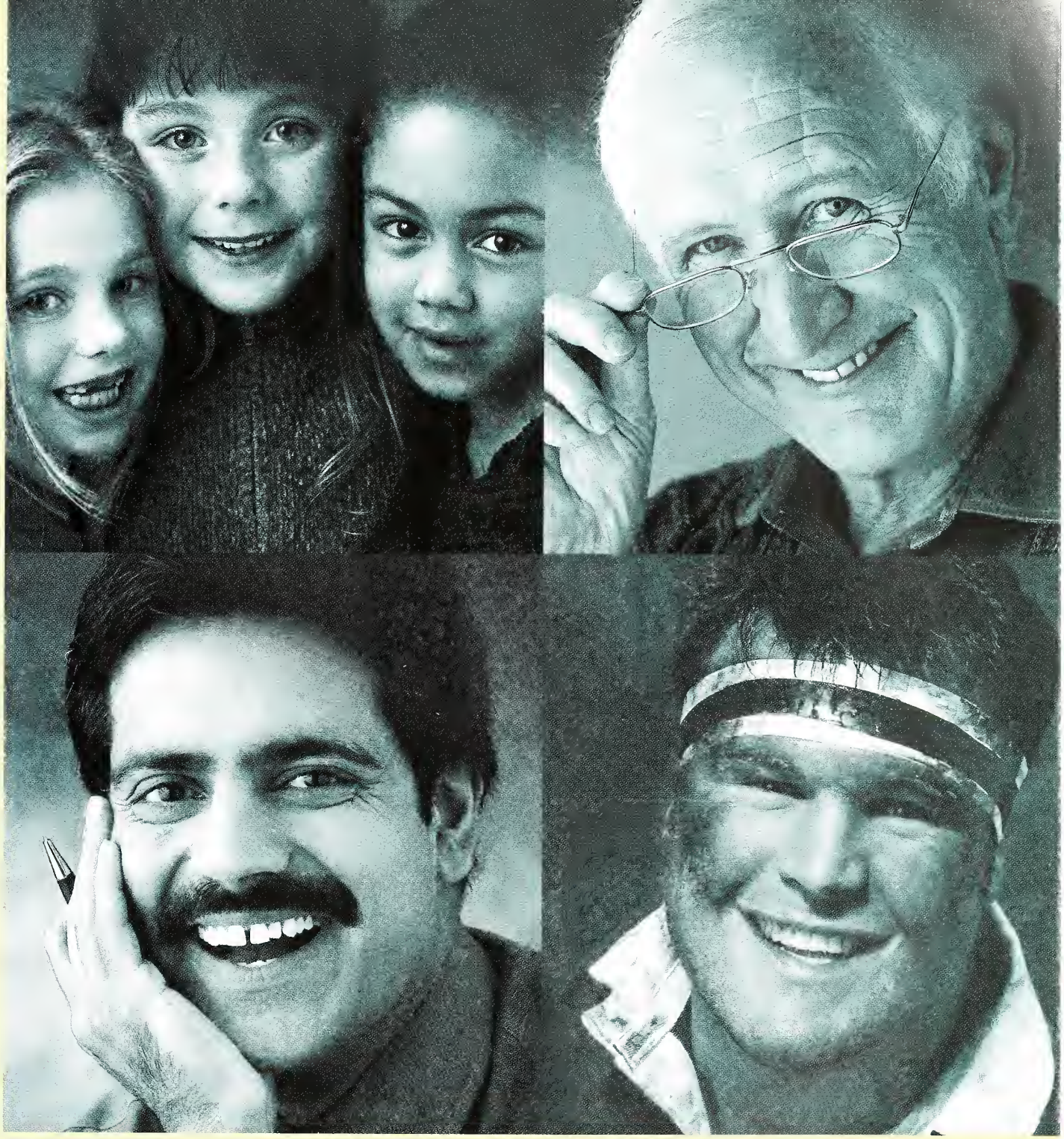
ACTION PLAN

1. For the next ten patients who have had a stroke, list in your practice workbook any resulting physical problems? List the drugs they are taking for stroke.
2. For the next 20 patients taking low dose aspirin, how many are also taking dipyridamole? What dose of aspirin do the local doctors recommend?
3. Consider patients not taking routine low dose aspirin. Do you think they would benefit from a daily dose? How would you discuss a general policy for your pharmacy with the local practitioners?

RESOURCES

The Stroke Association provides practical support to people who have had strokes, their families and carers. It offers a range of leaflets (some free) on reducing the risk of stroke and coping with its effects

Stroke House, Whitecross Street, London EC1Y 8JJ.
Tel: 0171 566 0300
Fax: 0171 490 2686



Control of Diabetes

Written by Terry Maguire

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CHEMIST & DRUGGIST

Learning Objectives

Having studied this module the pharmacist should:

- *Appreciate the benefits of controlling blood glucose*
- *Identify the acceptable blood glucose range for diabetes patients*
- *Understand the reasons why patients fail to achieve good diabetic control*
- *Appreciate the advantages of home blood glucose monitoring*
- *Recognise the relevance of testing for ketone bodies, glycosylated haemoglobin and microlbuminuria*

Control of Diabetes

Controversy has existed for many years over the gains and risks of rigidly controlling blood glucose in diabetes mellitus. How strictly a diabetic should be controlled has now been established by the DCCT trial*. Obviously control must be of such a degree as to relieve symptoms and maintain normal body growth and personal well-being but whether it must be so finely tuned that blood glucose never rises above 8 or 9 mmol/L as in normal individuals is being questioned by some authorities. The accepted blood glucose range for a IDDM patient is 4-8 mmol/L and for a NIDDM patient is 4-9 mmol/L.

NOMINAL BLOOD GLUCOSE RANGE

IDDM 4-8 mmol/L

NIDDM 4-9 mmol/L

Strict control of diabetes in pregnancy is important and here the advantages to both mother and baby are clear cut and well documented.

Reasons for failing to achieve good diabetic control include:

- *Patient non-compliance to prescribed medication.*
- *Inadequate use of test results as a means of providing control.*
- *Emotional problems (resulting from obligatory regimentation).*

Measurement of Glucose Levels

Measurement of glucose levels is, at present, the means which underpins the control of diabetes for most patients and it can be performed on blood or urine samples.

Urine glucose testing as a means of monitoring the standard of glycaemic (blood sugar) control has long been known to be inadequate. At best it is semi-quantitative and does not accurately reflect the concomitant blood glucose value. This may be due to the rapidly changing blood glucose value during the collection of urine in the bladder and the variability of the renal threshold for glucose. In the past urine tests were the only available method for monitoring the standard of control achieved but now blood glucose monitoring strips are available on prescription and are preferable.

However, the detection of glucose in urine can be a quick and cheap way to identify those who would require referral and further investigation by their G.P.

* The DCCT Research Group. The effect of intensive treatment of diabetes on the development and progression of the long term complications in insulin dependent diabetes mellitus. N Engl J Med 1993; 329: 977-986.

Blood Glucose Testing

Blood glucose testing provides more detailed information than urine test results. A patient's fasting glucose should be less than 6 mmol/L. Having a level above this is not diagnosis of diabetes but merely suggests that the client should see their doctor for further investigation.

In patients who have been diagnosed as diabetic, blood glucose test results are an important method of facilitating improvement in the quality of blood glucose control.

The advantages of home blood glucose monitoring include:

- *Blood glucose may be determined at any time of the day*
- *May be carried out in the home/work environment*
- *Provides an instant feedback to the patient allowing adjustment of treatment (adjustments are made on trends not one-off results).*

Meters are particularly useful for patients who have difficulty in comparing colours. Diabetes causes some long-term visual complications which have been shown to reduce the ability of some diabetic patients to tell the difference between colours. Meters when used properly will provide more accurate results and are preferable if patients are expected to adjust insulin dosage. Whereas the test strips are available on prescription the meter must be bought and this may be a prohibitive expense for some patients.

Diabetic patients who wish to purchase a glucose meter can claim exemption from V.A.T. by putting in an appropriate form. Details of this form can be obtained from your local Customs and Excise Office or from the instrument manufacturers.

Meters can give a false sense of security, as some patients believe that they do not produce false results. Patients need clear instructions on how to use and calibrate their instruments.

Quality Control

Since the result of a blood glucose test, read visually or by a meter, is quantitative or semi-quantitative and will be used to manage the patient's diabetes, it is important that a suitable quality control scheme is implemented.

Measurement of Ketone Bodies

The detection of ketone bodies in the urine of diabetic patients is of significance since their presence indicates the need for a change in insulin dosage or other management. During periods of acute infection, surgery, gastrointestinal disturbances or other stress, and whenever the management routine does not control the disease, the urine of all diabetics should be checked for the presence of ketone bodies.

Whereas three ketone compounds are produced in ketonuria it is generally satisfactory to determine the presence of one of these compounds. Specific tests do exist for the determination of each of these substances but they are not generally used.

Measurement of Glycosylated Haemoglobin (HBA_{1C})

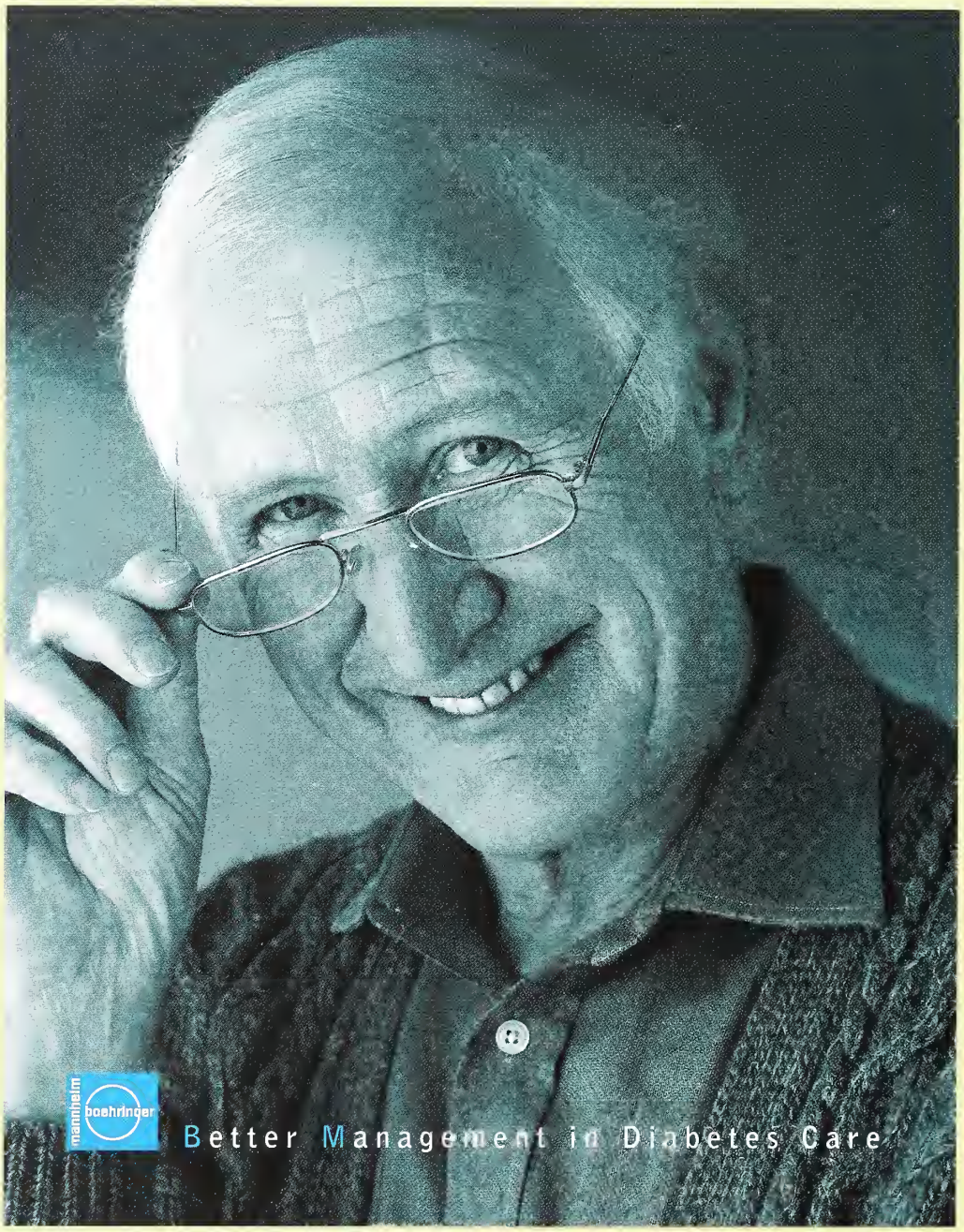
The most accurate method of determining diabetic control over a period of time is to measure glycosylated haemoglobin. The formation of glycosylated haemoglobin, haemoglobin with a glucose molecule attached, is a slow continuous process occurring during the lifespan of a red blood cell. In the presence of high concentrations of glucose a greater amount is formed and, therefore, this measurement can be used to accurately indicate the degree of control which the patient has maintained over a period of weeks and even months.

The principle behind this electrophoretic measurement is related to the discovery that the addition of a glucose molecule to haemoglobin reduces the net positive charge density of the haemoglobin molecule making it less positive in nature. This technique is not practical at present for use in a community pharmacy but is used in out-patient reviews.

Measurement of Microalbuminuria

Conventional proteinuria tests have been relatively ineffective in identifying diabetic nephropathy since the amount of protein required to give a positive result was such that nephropathy was advanced before it was identified.

A recently introduced test, Micral Test II (Boehringer Mannheim UK), is designed to measure microalbuminuria and should identify incipient nephropathy, the first indications of kidney disease. Microalbuminuria is diagnostic of stage III renal failure which is of vital significance in the development of nephropathy. It is a stage in which further progression of the disease can potentially be stopped by a number of treatment options, including the optimisation of metabolic control, lowering of blood pressure and reduction of dietary protein. Failure to stop the progression of the disease will lead to end stage renal failure which is irreversible. This urine dip-stick test employs monoclonal antibodies.



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Drying out time

Last week's National Dry Night Campaign (June 4) aimed to highlight the problems that bed-wetting brings to both children and their parents. London GP Dr Rob Hicks talks about his own experience of managing the problem in his surgery

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1093), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JULY 11, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To recognise the problem of nocturnal enuresis
- To be aware of the incidence of the problem
- To understand the psychological impact of the problem
- To be aware of drug and non-drug management of nocturnal enuresis

Bed-wetting is not funny, it's soul destroying. We all need to be aware of how much suffering bed-wetting can cause to child and parent, and should encourage people to ask for the help that is available so they can get on with living a normal, happy life.

Definition

Nocturnal enuresis, or bed-wetting, is said to be present when a child of five years or older is dry by day, but still wets the bed at night at least three times each week, and has no causal congenital abnormalities or underlying problems.

Nocturnal enuresis can be primary: where someone has never been dry at night, there is no obvious cause, and delayed maturation is the explanation. In secondary nocturnal enuresis, there has been a period of night-time dryness, but for some reason the person has started wetting the bed again. The most common reasons for this include urinary infection, or emotional causes such as a change of home or school, or the birth of a new sibling.

Case study

I had looked after nine-year-old Desmond for about six months. I saw him with the usual coughs and colds that any schoolchild gets in the winter and the occasional rash. It was always his mother who came with him and although I couldn't pinpoint it, I had that odd feeling that something else was wrong.

Despite making sensitive enquiries about whether there were "any other problems" nothing was forthcoming and I started to believe that maybe it was my imagination after all.

Spring arrived and in they came again, this time with Desmond's younger sister Tabatha. She immediately announced that they were going on a school camping trip in the summer but Desmond didn't want to go because "he still wets the bed".

Out came the guilt from both Desmond and his mother. She had wanted to ask for help but was ashamed and Desmond was terrified of his friends finding out. It had taken his little sister and a potential crisis to trigger the process of resolving the problem.

Positive support and practical tips combined with a course of medication helped Desmond enjoy his school camping trip. In fact, his mother told me that they saved enough money since he stopped wetting the bed to afford to buy a tent and go camping as a family.

Wetting the bed is distressing for both child and parent

Incidence

There are over one million people in the UK who suffer from nocturnal enuresis. It may come as a surprise to hear that only half of these are children and teenagers. The other half a million are adults over the age of 17 years old in whom the problem has persisted since childhood and has not been resolved.

By the time they reach three years of age, most children will be dry at night. However, between 15 and 20 per cent of five-year-olds, one in 20 ten-year-olds, and a staggering one in 100 adults over 20 years of age still regularly wet the bed. It's true that most people will grow out of bed-wetting but this is not a reason to be complacent. While a person is still wetting the bed and waiting for that time to stop, if it does at all, then they will be suffering unnecessarily.

Box 1: Incidence

Age 5	>1:6
Age 10	1:20
Age 20	1:100

Psychological impact

Disturbed sleep, embarrassment, and humiliation are all commonly described by children and adults who wet the bed.

Normal childhood development is hindered because children are frightened of taking part in activities like school camping trips in case their secret is found out. There are many reports of children and teenagers suffering low self-esteem, and feelings of being dirty and unhygienic are common. Adults, too, fear being found out and avoid forming good relationships.

The parents also suffer. I see parents of children who wet the bed and they are exhausted, and at the end of their tether. They describe how they feel guilty that they must have done something wrong for their child to still be wetting the bed. They are terrified about the way they

Continued on PVIII ▶

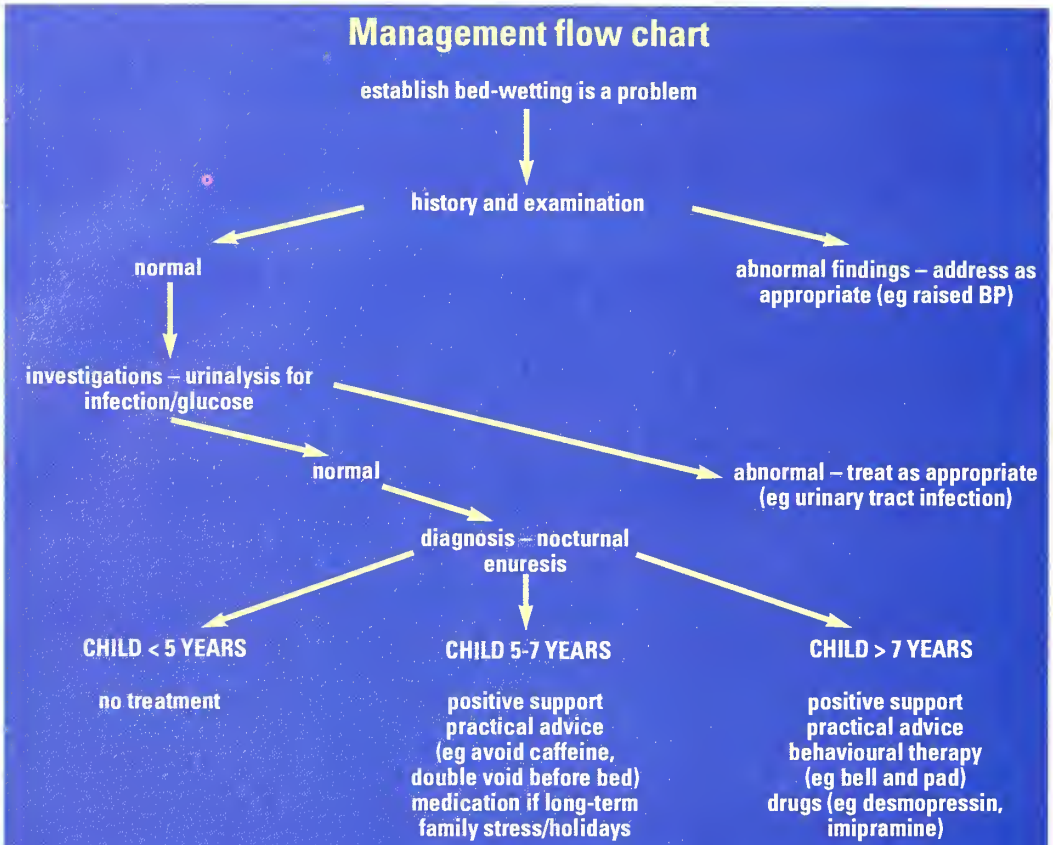
Continued from PVII

feel towards their child, wanting to lash out and punish them, which, sadly, is all too common.

Is it any wonder this happens when every night they have to change the child's bedding and pyjamas? Most of their day is spent washing and waiting for the same thing to happen the next night. It's expensive, too. Economists say that it costs a family more than £1,500 a year if a child is wetting the bed three nights a week.

It's not long before the cycle of guilt develops. The child feels guilty for wetting the bed and is punished. About one-third of parents admit to punishing their child, which reinforces the child's guilt that they have done something wrong. This negative behaviour simply perpetuates the situation and suffering.

There is research evidence that suggests that there may be a genetic predisposition to bed-wetting. If one parent was a bed-wetter, there's a 40 per cent chance of a child following suit. If both parents suffered then there's a 70 per cent chance of a child suffering, too. Knowing this helps people to appreciate that it's not their fault.



Diagnosis

When a diagnosis of nocturnal enuresis is made it is usually straightforward. This is because the parents bring their child at a time of crisis, such as a forthcoming school camping trip or a party where the child will be staying overnight, and tell you that the child still wets the bed. They are in a state of panic because they have coped with the problem at home, but what are they going to do now? Often it's not the GP but school nurses or health visitors that identify the problem.

Only one in six people seek help, so the difficulty is identifying it before this crisis time. This is why it is important not to be frightened to ask patients if bed-wetting is a problem. After all, it is the most common chronic childhood illness.

Once other possible causes of nocturnal enuresis – like general developmental delay, anatomical abnormality, infection, diabetes mellitus, constipation, or sexual abuse – have been eliminated then treatment can begin.

Non-drug management

Without doubt the most important part of successful treatment is positive support and understanding. Telling the sufferer that it's not their fault and the parents that they haven't done anything wrong goes a long way in helping them come to terms with the problem. And telling them that they are not alone and that others have had the same problem solved gives them hope.

Helping children to understand how the kidneys work, and that they continue to work even during sleep, is useful in their treatment.

Under the age of five, all that's needed is reassurance that most children will be dry by night by the age of five – ensuring that this is done in a

supportive and not a dismissive manner.

- **Practical measures**

Parents of children between the ages of five and seven can be offered practical advice in addition to positive support. Avoiding drinks like cola, tea or coffee which contain caffeine, perhaps having the last drink of the day a little earlier than before, and emptying the bladder before going to bed, are all simple measures that help.

Double voiding, where the child empties the bladder once and again five minutes later before bed, can help.

Practical advice, eg on mattress protectors, can be obtained from ERIC (Enuresis Resource and Information Centre).

- **Reward schemes**

For this age group and above, a reward system works well. Traditionally, people used a star chart system where the child received a star as a reward for each dry night. This was placed on a chart to show how good they had been, and how dry nights were possible. When an agreed number of stars had been achieved they were allowed to choose a special present.

Nowadays, reward schemes run by parents do follow the same principles but involve far more elaborate 'stars' such as computer games and money. Still, it does seem to work for a number of children and just goes to show how desperate bed-wetting can make parents feel.

- **Behaviour therapy**

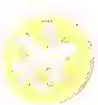
For the child who is seven or older, in addition to the positive support and practical advice, it is worthwhile to try either behaviour therapy or medication, or a combination of both.

The most successful form of behaviour therapy is training the bladder using a bell and pad. Essentially this involves a pad placed under the bed sheets which, when it comes into contact with urine, sets off an alarm bell. This wakes the child, who then learns to go to the toilet.

For those children who share a bedroom, an alternative is available where the pad is connected to a vibrating silent alarm. For this technique to work, the child must be co-operative and motivated. They must also be taught how to use it properly.

Over the years I have learned practical hints from the parents of patients of mine. Make sure the bell alarm is placed far enough away from the child so they cannot just reach out and turn it off; that the vibrating alarm is clipped securely to the pyjamas, otherwise the child may put it under the pillow where it cannot be felt; and if a child is electronically minded, don't waste your time trying this method because they will simply dismantle the equipment.

Using this technique it takes around three months for a child to become dry and the technique needs to be continued for about six more weeks after that. However, on average, half of those who become dry will start wetting again. Alarms can be borrowed or bought from local enuresis clinics or ERIC.



Medication

Drug therapy is not suitable for children under seven and should be reserved for special circumstances, such as when short-term control is needed.

Nevertheless, using medication is a successful way of giving the child and parents a break from the traumas of wet nights. It also shows the child what it is like to be dry and that dry nights are possible. It is often used when children are due to go away from home to stay with friends or on holiday.

Most people these days are using desmopressin as their first-line medication for nocturnal enuresis, which is a synthetic analogue of vasopressin, an anti-diuretic hormone. It comes as a nasal spray, which is stable at room temperature, or as tablets, which children seem to prefer

Daily administration brings dry nights in two to three weeks and must be continued for at least six weeks after dryness is achieved. It is successful for around 70 per cent of those who receive it.

In the past, the first-line treatment was with the tricyclic antidepressants imipramine and amitriptyline, and less commonly with nortriptyline. However, the side effects associated with this family of drugs, which included behavioural disturbances, meant that compliance was not good and it is now less favoured. Relapse after withdrawal of these drugs is also common. Where they are used, treatment is usually for three months but can be extended following a full re-assessment and physical examination.

Oxybutinin is also licensed for nocturnal enuresis management but is less commonly used.

Conclusions

Bed-wetting is a distressing condition that should be taken seriously. It causes problems not only for the sufferer but for their family. With patience and understanding, support, medication, and practical advice, people should be relieved of the problem and able to live full and happy lives.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2000.*

ACTION PLAN

1. Consider children suffering from nocturnal enuresis. How many of them are prescribed medication? How many use mechanical devices?
2. What devices do you sell? Should you increase your range?
3. How would you counsel a parent about nocturnal enuresis suffered by one of their children? Brief your staff on how best to handle the problem sensitively.
4. Make a note of any prescriptions for enuresis. Which drugs are prescribed? What is the age of the patient? Can you draw any conclusions?

RESOURCES

ERIC
The Enuresis Resource and Information Centre
34 Old School House
Britannia Road
Kingswood, Bristol BS15 2DB
Tel: 0117 960 3060

Drug tariff concluded

In the final article in the series, Martin Jenkins, deputy director of pharmaceutical advisory services at the Prescription Pricing Authority, gives some practical tips on using the Drug Tariff

The final article in the Drug Tariff series draws together the points raised in the previous articles and, with the reimbursement rules, offers practical guidelines for pharmacists to ensure compliance and minimise disallowed or returned prescriptions.

There are four simple steps:

- check the Drug Tariff preface
- know and understand the reimbursement rules
- know when to endorse
- know when not to endorse.

Each of these steps is discussed below.

Check the preface

It is imperative that pharmacists read the preface thoroughly each month and pay particular attention to the Advance Notice. This advises of future changes to the Drug Tariff and the month they become effective.

The preface also shows all changes to the Drug Tariff for the current month other than price changes for Parts VIII and IX. It will therefore show what items have been added, deleted or amended in Parts VIII and IX, or where other changes such as the Part VIII category or basis for price calculation have occured. Changes to other parts will also be indentified.

Late changes

Occasionally, there may be changes which, because of the production timescale outlined in the first article, cannot appear in the relevant Drug Tariff. Where agreement is reached between the DoH and the Pharmaceutical Services Negotiating Committee (PSNC), these changes can be implemented although not listed in the Drug Tariff. Normally the PSNC will seek to publicise this. Typically it may be a change from Category A or C to Category D for a Part VIII item which has become in short supply.

Zero Discount (ZD) changes

Before November 1996, pharmacists had to endorse ZD against all items included within the ZD list in Part II of the Drug Tariff. However, since then, the list has been split into two parts. List A consists of those items for which it has been confirmed that no pharmacy contractor receives a discount. No endorsement is required and ZD will be applied automatically when the prescription is processed. List B covers those items for which, while normally not discounted, it may be possible for a pharmacy contractor to receive a discount. Pharmacists must endorse ZD against those items for the ZD endorsement to apply. If there is no ZD endorsement, no discount will be applied.

Individual items may move between lists as a result of information received. Pharmacists should check the preface each month for any such changes.

Blacklist changes

Changes to the 'Blacklist' normally occur infrequently and receive advance publicity. Nevertheless, changes can be missed. With the most recent changes in July 1997, specific pack sizes for a number of items were blacklisted. However, the PPA continues to receive prescriptions endorsed with these pack sizes. It is not possible for the PPA to return any of these disallowed items for retrospective amendment and resubmission and therefore no payment can be made.

Price changes

Price changes are not specifically included in the preface but are indicated in the Drug Tariff by ▼ for price reduction and ▲ for price increase. Changes to the text relating to code, product description, or the inclusion of a new product are indicated by a vertical line in the right-hand margin.

Reimbursement rules

Some of the reimbursement rules are highlighted below – this is not an exhaustive list.

Professional fees

All prescriptions attract a professional fee and no specific endorsement is needed. However, claims for additional fees generally must be indicated by endorsement, ie, extemporaneously dispensed items or urgent prescriptions. Certain items (ie combination packs) attract more than one professional fee and normally this should be reflected in the 'number of items' box at the bottom of the prescription form. Where a doctor orders a variety of flavours, each flavour dispensed will attract a professional fee and the endorsement of each flavour will suffice.

Calendar packs

If a product is packed in a calendar pack as per Drug Tariff definition (Part II, Clause 10C) and the quantity prescribed coincides with the calendar pack or sub-pack size, the reimbursement will be made for the prescribed quantity.

If the quantity prescribed does not coincide with the calendar or sub-pack size, but a whole number of sub-packs have been dispensed, then reimbursement will be for that number of sub-packs. If the quantity is halfway or less between sub-packs, then the lower number of sub-packs should be dispensed.

If you have dispensed the exact quantity ordered, endorse clearly to show the quantity dispensed, differentiating this from any pack size endorsement. An endorsement of 'ex' will be sufficient to show that the exact quantity has been dispensed.

If the item is packed to contain more than one month's supply and three or more packs are prescribed, ensure that the prescription is clearly endorsed to show the actual quantity supplied.

Special containers

If the product is supplied in a special container as defined in the Drug Tariff (Part II, Clause 10B) and the quantity prescribed is equivalent to one or more special containers, then the appropriate number of special containers should be supplied.

If the quantity prescribed is not an exact match for pack size, supply sufficient to achieve the nearest possible quantity by means of whole packs and endorse the prescription form as such.

Note the list of bath additives and similar preparations given in relation to Part II, Clause 10B(iii) which are defined as special

containers. Other sizes of these products may be available which are not considered to be special containers for reimbursement purposes.

When to endorse

Part VIII

For items listed in Part VIII, excluding Category D items, if there is more than one pack size listed for the product, then endorse pack size only.

For Category D items, if the product dispensed is the one shown or one of equivalent value then no endorsement is needed. If the value is different, then endorse with product/supplier.

If an item not listed in Part VIII is prescribed generically, then endorse supplier plus pack size where appropriate.

Proprietaries

If the item is prescribed by brand name, endorse pack size if more than one size is available.

Zero Discount

If the prescription is for an item for which no discount has been received (Part II, Clause 6) and it is included in the ZD List A, no endorsement is required. If it is included in List B, endorse ZD to ensure that the cost of the item is not included in the total to which the appropriate deduction rate is applied.

If the item is not included in either list, ZD cannot be claimed, even if no discount has been given for the item.

It should be noted, however, that some of the items not individually listed may be covered by broader categories such as special formulations (List B), Borderline Substance Foods shown in Part XV (List A) etc.

Broken bulk

If the prescription is for a product not routinely used, and for which stock will be left after dispensing that cannot then be readily used up, broken bulk may be claimed if the minimum quantity available was purchased – providing the item is not in Part VIII or Part IXA. Payment will be for the quantity purchased, but no further payment for the item (except fees) will be made within six months until the total pack quantity has been dispensed.

Points to remember:

1 If broken bulk is claimed and is used up within the six months, then a fresh broken bulk claim must be made if applicable. Any stock left from broken bulk has been paid for by the NHS and should only be used for NHS dispensing.

2 If two or more prescriptions are submitted to the PPA in one month and the total quantity dispensed exceeds two-thirds of the container size, then the item falls outside the definition of 'not normally dispensed'.

Out of pocket expenses

Out of pocket expenses cannot be claimed for items listed in Part VIII Category A, Part IXA and Part IXR.

Claims can be made where, in exceptional circumstances, expenses have been incurred in obtaining a drug, appliance or chemical reagent other than those that are exempted.

For such a claim, full details should be forwarded to the Prescription Pricing Authority with the prescription form. The first 10p of any claim is not reimbursed.

Miscellaneous

If the prescription is for an antibiotic mixture or similar preparation that is reconstituted from granules or powder (Part II Clause 13), then reimbursement is based on nearest pack or number of packs needed to cover quantity ordered.

If the prepared product is stable for less than 14 days and the quantity ordered is for more than 14 days (Part IIIA, Clause 2E), and it is necessary to supply the item at intervals because of the stability, then the *extra* number of containers supplied should be endorsed for the relevant number of additional fees to be reimbursed.

If the prescription requires the product to be especially made up in the pharmacy (Part IIIA, Clause 2A) then it should be endorsed as extemporaneously dispensed, aseptically dispensed, or extemporaneously sterilised as appropriate.

If the prescription is for a dressing or wound care product, an appliance or a reagent, then it may be supplied only if listed in the relevant part of the Drug Tariff.

No endorsement is necessary if a prescription is complete, but it is helpful to endorse with the code number of incontinence or stoma appliances to help ensure correct reimbursement.

If the prescription is for a dressing or wound care product, an appliance or a reagent which is not listed in Part IX of the Drug Tariff, the prescription cannot be reimbursed.

If the prescription is for a medicine listed in Part XVIIIA, the prescription will not be reimbursed. If it is in Part XVIIIB the prescriber must endorse 'SLS'. Note, the pharmacist is not entitled to endorse 'SLS' if the prescriber has omitted to do so.

If the drug is not listed in Part XVIII, it can be dispensed and will be reimbursed.

If the prescription is for a controlled drug (Part IIIA Clause 2 F), endorse 'CD'.

When not to endorse

Do not endorse prescriptions for ZD List A items – ZD is automatically applied.

No endorsement is required for items listed in Part VIII Categories A, B, C and E, unless more than one pack size is listed in which case endorse with the pack size.

Responsibility for the appropriateness and correctness of any endorsement lies with the pharmacist.

PHARMACYupdate: distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of **Genus Pharmaceuticals**, *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the July 11 issue, which will cover this week's CPP-accredited modules, together with those in the June 20 issue.

The MCQ paper for the May modules will be enclosed in next week's *C&D* covering:

- Balanced diet (1089)
- Thyroid gland (1090)
- Angiotensin II antagonists (1091).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

C&D in association with

GENUS PHARMACEUTICALS

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Don't fall behind with your continuing professional development. Pick up the phone and speak to Sue Cheeseman on 01732 364422 if you need more information, or fill in the coupon below and send it with a cheque for £15 (plus £2.62 VAT) payable to Miller Freeman UK Ltd, which will register you for 12 months for certificated marking.

Pharmacyupdate is supported by **Genus Pharmaceuticals**

GENUS PHARMACEUTICALS

To Sue Cheeseman. Please enrol me on the **Pharmacyupdate** telephone marking service for 1998. I enclose a cheque for £17.62, made payable to Miller Freeman UK Ltd.

Name.....

Address.....

..... Postcode.....

Daytime phone number..... Fax.....

Signature..... Date.....

Send this completed form to Sue Cheeseman, Chemist & Druggist, Miller Freeman UK Ltd, Miller Freeman House, Sovereign Way, Tonbridge, Kent TN9 1RW.

NPA seeks assurance over PCGs

Concern that pharmacists may be excluded from primary care groups as a result of deliberate actions by other parties with vested interests has been raised by the National Pharmaceutical Association.

In particular, it believes dispensing doctor appointments to primary care group boards could bias the PCG when considering dispensing and supply of medicines. As such, the NPA is seeking confirmation from the Department of Health that PCGs are not to have a dispensing function.

DoH head of primary care Andy McKeon has told the Association that while the DoH would be concerned about bias relating to dispensing, it was not one of the areas identified as a PCG function and, therefore, the potential conflict of interest should not arise. However, the NPA board at its May meeting last week believed this falls short of a guarantee that PCGs would not be involved in dispensing, especially as it is hearing reports that some groups working towards becoming primary care trusts had indicated that they saw the distribution of medicines as being a function of the trusts.

NHSE guidance issued to health authorities indicates that a PCG operating at level 3 or 4 under the new arrangements would have responsibility for managing its area's drug budget. As such, the Board felt there may be a potential conflict of interest if a dispensing doctor is on the PCG board.

Mr McKeon stated that he had asked colleagues at the DoH to ensure that pharmacy organisations were involved in producing the guidance on the development of Health Improvement Programmes.

Working Time Directive The NPA is to inform the Department of Trade and Industry of its concern over the practical difficulties many pharmacists would face in meeting the requirements of the Working Time Directive.

The Directive, which includes proposals to introduce a maximum working week of 48 hours, a 20 minute rest break for each six hour period worked and a minimum holiday entitlement of three weeks (rising to four weeks in November 1999), will apply to all pharmacy staff, although individuals can choose to 'opt out' of the entitlement.

While very few non-pharmacist pharmacy staff worked more than 48 hours a week, this was not the case with some employee pharmacists. And with many small pharmacies relying heavily on seasonal and casual staff over holiday periods, the obligation to provide these employees with paid holiday would be an additional burden on employers.

The NPA will support the proposal that implementing legislation will require employees to work for a qualifying period of three months before the entitlement arises.

EDI working group The NPA is to establish an electronic data interchange (EDI) working group consisting of seven Board members which will report back to the Board in the autumn.

Patient Packs No reply had been received from the DoH regarding patient packs. The Association had written in April over the lack of progress being made and asked the DoH whether it intended to reconvene the Patient Pack Working Group to work towards resolving the outstanding difficulties associated with the implementation of patient packs.

Resale Price Maintenance Solicitors are preparing CPAG's legal case to present at the Leave Hearing, where the OFT will attempt to show that there has been a material change in circumstances since 1970, and have RPM overturned by the Restricted Practices Court. The Hearing is scheduled for September or October.

Reform of RPSGB's disciplinary machinery The Board is concerned about the Society's proposal that would allow a disciplinary tribunal to award costs where 'one of the parties had, by his/her conduct of the case, given rise to excessive delay and expense to the other party'. 'Excessive delay' is subjective, and may result in those appearing before the tribunal feeling pressured into moving rapidly through the case for fear of having costs awarded against them.

RPSGB's pharmaceutical services to drug misusers The Board supports the principle of allowing pharmacists to keep electronic records for the dispensing of controlled drugs. However, for this to happen, software programmes would need to be modified to allow pharmacists to comply with current regulations.

Reclassification of medicines The NPA is to argue against proposals to give GSL status to potassium chloride and a number of local anaesthetics – lignocaine, lignocaine hydrochloride and benzocaine. It disagrees with the MCA's view that wider availability of potassium chloride products used in the treatment of diarrhoea would benefit the public because acute diarrhoea can occur suddenly and without warning, saying that most people have access to a pharmacy that stays open from 8.00am to 10.00pm. It was worried that the products may be used inappropriately or conditions allowed to worsen if there was no pharmaceutical advice available.

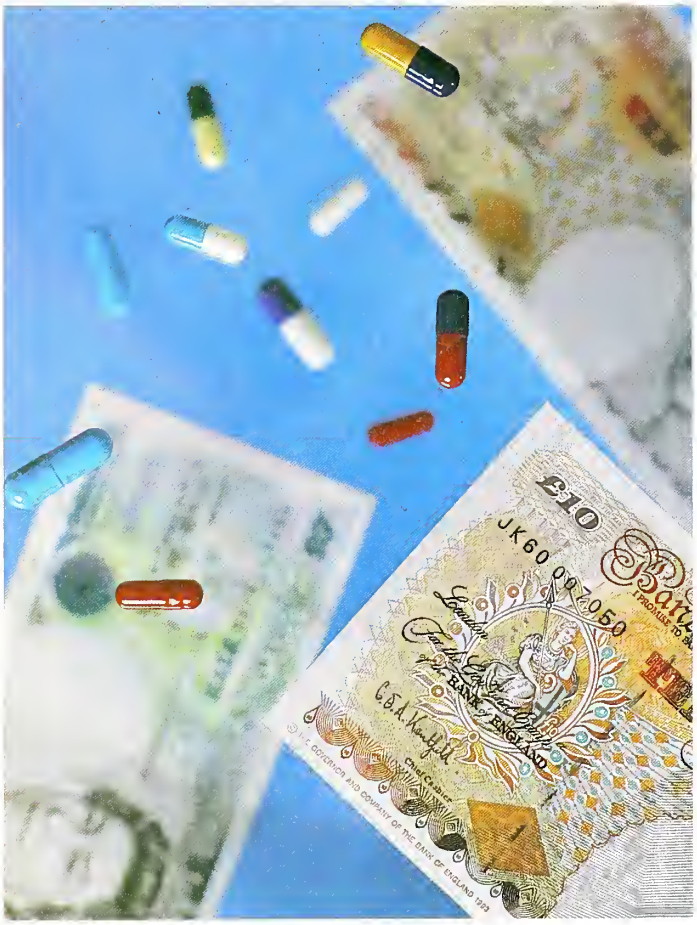
Restrictions on sale of vitamin B6 The NPA supports proposals from the Ministry of Agriculture, Fisheries and Food to introduce legislation which would restrict the level of vitamin B6 in dietary supplements sold under food law to 10mg. Assuming that the research linking excessive usage of vitamin B6 to peripheral neuropathy was shown to be valid, the level of B6 in food supplements should be limited to 10mg. Products should carry a warning about the dangers of prolonged use, and food supplements with a daily dose of vitamin B6 above 10mg be restricted to sale in pharmacies only.

RPSGB Working Group: Getting Research into Practice The Association has outlined a number of ways in which the NPA used research evidence and agrees that community pharmacy practice research was vital if new funded roles were to be secured. Very little good community pharmacy practice research existed however, mainly because community pharmacists, in general, lacked the culture, time and funding to undertake practice research. Other obstacles, included a lack of facilities for literature searches. The association wants the RPSGB to continue to lobby for the funding of an R&D infrastructure (Culyer funding) to support the development of community pharmacy research practitioners.

NPA Christmas Cards The sum of £1,505 has been raised for the RPSGB Benevolent Fund from the purchase of the NPA Christmas Cards.

The NPA Home Page The number of people accessing the NPA's Home Page has increased from 5,000 per month at its launch in September 1996 to a figure of 25,000 per month in January 1998.

Number crunching made easy



Why wait for an accountant to give you an annual profit and loss account, when you can compile your own every month. Peter Robinson reports

Think about the hundreds of businesses that spring up every year, many of which are destined to fold, leaving their proprietors scratching their heads about what went wrong.

A business often fails because of poor financial control – or no control at all – and because the management does not know its true financial position.

Many self-employed people and proprietors of small businesses get into financial trouble simply because they do not keep proper financial records.

Accountancy is for accountants, book-keeping is for book-keepers, but everyone in business – including pharmacists – should record their transactions. These transactions should be entered into a standard, analysed cash book, petty cash book, and perhaps a day book.

The next stage is to transfer the totals of these columns to a report form (see example below), which I call a 'Robinson Report' – I give it to my clients at the end of each month.

This report has most of the financial information you need to see how your business is performing. You should also be able to work out:

- your current cash position
- how much money you owe
- how much money is owed to you, and for how long
- whether you have made a profit or loss
- your gross profit and net profit as a percentage of turnover.

It does not matter if you have not had book-keeping or accountancy experience, you should still be able to gather this financial information.

If you examine your Robinson Report at the end of each month, you will see how your business is performing. You could start with your turnover and gross profit – have you made enough gross profit to pay for all your expenses? Is the gross profit, as a percentage of turnover, high enough, and how does it compare with other pharmacies? You can then check whether your expenses can be cut.

Moving on to the net profit or loss. If you have made a profit, is it enough to make a decent living? If it's a loss – what are the reasons? Are you drawing too much money out of the business and starving it of funds?

You, or your manager, should compile this report at the end of every month, instead of waiting for an accountant to draw up a profit and loss account and balance sheet at the end of your financial year. After all, you need to know what is going on now, not what took place 12 months ago.

Having examined the report closely, you will spot danger signals and should have enough time to correct them, or seek advice on how to correct then before they develop into major problems.

Those of you who spend a little time doing your accounts – probably not more than a couple of hours a week – will know more about your business than if you left it to an accountant.

Don't forget, the new self-assessment tax scheme means you have to keep proper financial records. An inspector from the Inland Revenue and Customs & Excise would be delighted to see accounts kept in this way.

Your Robinson Report will provide most – if not all – of the information required to file the self assessment tax return.

Why not start one now?

Peter Robinson advises small firms on setting-up business and book-keeping. He has written a booklet 'Who needs an accountant', priced £4.95. For more information, telephone 0161 626 7323.

A Robinson Report

1997		£
January sales		17,195.87
Less purchases*		8,367.34
(Gross profit		8,828.53
		50% of sales)
Less expenses		
Security		100.00
Phone		200.00
Electricity		50.00
Motor expenses		
repairs	150.00	
fuel	275.00	
		425.00
Wages		2,000.00
Advertising		100.00
Rent		120.00
Rates		200.00
Insurance		100.00
Sundries		50.00
Bank charges		100.00
		3,445.00
(Net profit		5,383.53
		31% of sales)

VAT (Jan)** £3,009 - £1,800 = £1,209

Bank opening balance	£19,441.00
Bank closing balance	£23,271.00

Debtors	£6,000.00 Current	60 days £1,500.00	90 days £500.00
Creditors	£4,500.00	All 30 days	

Capital items bought	Nil	*Important for depreciation and balance sheet*
Capital items sold	Nil	

This report should be set up in a style that suits your company. You should allow scope to add items where appropriate. You can then photocopy it or file it in a computer.

* Medicine and other goods for sale

** *Note:* The VAT shown on this report may differ from your average monthly liability. If the majority of your sales consist of prescriptions, you will probably be due for a refund. You must take care to separate your prescription and OTC sales, as the former is obviously zero rated. For more information on this, ask your Customs & Excise office for VAT notice no. 701/31.

Protecting people

Health and safety issues are not a bureacratic nightmare. All it takes to make your pharmacy safe is a common sense approach, as Bob Debell reports

Your first reaction when you glance at a feature on health and safety in the community pharmacy could be: 'Fear and trepidation'; 'bureaucracy'; 'yet another restriction on the way we work'.

All of us who run small businesses suffer from 'legislative overload'. My own filing cabinet bulges with Inland Revenue, VAT and Companies House papers. And yet I embrace the health and safety legislation quite happily. I always think of my children. If my son or daughter were to work somewhere, how safe would I want that workplace to be? The answer is absolutely safe.

Why worry?

The community pharmacy is not in itself a dangerous place. Neither the Leeds nor the London press offices of the Health and Safety Executive (HSE) are able to recall a prosecution of a community pharmacist in the past year. Let's say you're unlikely to receive a surprise visit from an HSE inspector. The HSE, like most statutory bodies, is short of resources and is bound to concentrate on higher risk areas, such as small chemical works and engineering shops.

So why should a community pharmacy take any notice? Why invest in creating a written policy? Why bother to train staff to evacuate the premises? Is it worth putting notices all over the walls about fire escapes?

The answer is simple: you cannot afford to ignore these issues. You should take reasonable steps to operate a safe environment for patients, customers and staff. Imagine the publicity if a patient was badly injured by a falling display cabinet, and you and your staff were prosecuted not only for having a dangerous structure, but also for not taking any steps to make it a safe place. Imagine if the injured patient was your own child.

Basic principles

Making your pharmacy safe is relatively straightforward. Legislation says it should be as safe 'as reasonably practicable'. There are a large number of Acts and Regulations which every employer must obey. It does not really matter whether you know the list, from 200-year-old laws to last year's regulations. You can act legally and safely by knowing the basic principles without committing the list of acts to memory, just as you can dispense by referring to manuals such as Martindale or MIMS without committing the whole book to memory.

There are a number of things to be done. The first is often misunderstood: any employer with five or more employees must have a written health and safety policy. All employers must operate safely, whether they have thousands of employees, or whether they are a self-employed person working alone. In fact, most pharmacists will exceed the limit of five, which comprises the pharmacist, full- and part-time staff and locums.

Even with fewer than five employees, you need a written list of your safe practice. Model policies can be obtained from a number of sources, including Pragmatic Training Services or the National Pharmaceutical Association.

Next you have to identify and assess any hazardous areas. The assessment must be in writing, and it makes sense to file a copy at a different premises, in case your business premises is destroyed.

Your assessment will cover obvious items, such as drugs, patient body fluid samples, syringes and storage units. It will also need to cover less obvious matters, like the pharmacy kettle. (Small electric appliances kill about 25 people every year in the UK.)

Any competent person can carry out the assessment. You, or a senior employee, can help the assessor to ensure nothing in the pharmacy is overlooked.

Assess the risks

Once the risks have been assessed, you need to decide what to do about them. Basically, you will be required to take 'reasonable' steps to minimise the risk to employees, visitors and others on your premises. The pharmacist must take into account the fact that there is an unusually high proportion of vulnerable people such as the elderly, very young, and disabled on the premises. An engineering workshop has no such problem. The safety steps for a health care provider may therefore be unique. This simply means that in identifying risk, and in taking preventative measures, your specialist skills as a pharmacist have to be added to the health and safety activity.

Fire prevention is important. Most pharmacies are straightforward in terms of evacuating patients and customers. The backrooms may be more difficult, with stairs and exits easily blocked. Some pharmacies do not have a fire alarm at all. Some have never had a fire drill. In fact, you must have an alarm system, and a fire drill should be carried out at least once a year.

Do the staff know which type of fire each extinguisher works on, and which type of fire it actually blows up? Most people hurt or killed in a fire are injured as a result of their own action. Free fire training and advice is often available from the local fire prevention officer, and it is known to have saved lives.

The pharmacy's computer, car park area, 'gangway' between display units, and the way the doors open are some of the areas that need to be safe.

Health and safety concerns good management and common sense. You do not have to spend much to make your pharmacy legal and safe. Why not do it now? The life you save may be your own.

Bob Debell is managing director of Pragmatic Training Services.

Gehe's rich diet of acquisitions has catapulted its turnover 500 per cent to DM25bn over the past five years. It now plans to ease back its spending and concentrate on developing its multinational network, as Guy L'Aimable reports

Digesting an empire

To borrow an idea from Hanson plc: Gehe is a German company that's doing rather well over there. 'Over there' meaning major European markets, such as the UK and France.

AAH Group, Gehe's UK subsidiary, is beginning to realise the synergies of acquiring Lloyds Chemists and could account for 40-55 per cent of Gehe's turnover by 2000, according to Dieter Kämmerer, Gehe's chairman.

Since the acquisition of Lloyds Chemists last year, AAH Group has been busy restructuring. It has transferred £230m of wholesale business from Lloyds' depots to its own sites, begun to re-brand Hills/Lloyds into Lloyds Pharmacy, introduced the first Vantage re-brand for 23 years, and reduced its headquarter staff by 20 per cent as it moves to its new base in Coventry.

Michael Ward, AAH Group's chief executive, says the re-location to Coventry will be completed in July. "It's interesting that our main competitor [Alliance Unichem] has sought planning permission to do a similar thing [relocating Moss Chemists from Feltham to Chessington]. We take that as a compliment," says Mr Ward.

Dieter Kämmerer: competition has become tougher in Germany

The UK group, he adds, will benefit from its automated warehouses in Romford, Ruislip and Edinburgh. It is also automating a depot it recently bought in the Midlands. "The advantage of automation is that it brings great discipline. It brings 99 per cent efficiencies in what's packed and dispatched, and it gives us the ability to model stock ranges," he says.

By the end of October, AAH will have reviewed EPoS data for all the Lloyds stores, which will enable it to fine-tune merchandising and send out the right number of brands to cut wastage.

In France, Gehe owns the country's biggest drugs wholesaler – OCP Group – whose interests extend to Portugal, Italy and Belgium.

OCP's turnover, reflecting the flat French market, rose 1.9 per cent to DM10,650m last year, while its profits grew 14 per cent to DM135m. The French drug wholesale market is expected to perform much better this year.

Gehe is doing less well in Germany. Its drug wholesaling pre-tax profits fell 10.5 per cent to DM100m, while its turnover rose 1.4 per cent to DM5,188m.

Mr Kämmerer admits competition has become tougher in Germany, where Gehe's 19 per cent share of the drug wholesale market places it second behind Phoenix, with 28 per cent.

He says Gehe has introduced better packing lines in Germany, which have reduced its costs. "This year we expect business in Germany to grow 3.5 per cent," he says.

Complications could set in from government moves to encourage Germans to buy their own drugs. About 20 per cent of the medicines sold last year were bought privately. Mr Kämmerer concedes the change will have long-term implications for Gehe's German interests.

A difficult German market, however, is nothing new to Gehe and it explains why 78 per cent of the group's turnover comes from its overseas subsidiaries.

Gehe was founded in 1835 by Franz Ludwig Gehe. It originally supplied chemicals and raw materials, which it also processed into medicines. Gehe gradually expanded its drug production until, by the Second World War, it had become one of Germany's top suppliers. As its main production plants in East Germany were nationalised during the War, the company switched to drug wholesaling, which has remained its core business.

Recent events have forced Gehe to radically restructure its organisation. In 1992 Gehe's businesses were largely based in Germany – it was one of the first drug wholesalers to move into former East Germany two years earlier – but the local market was not thriving. Drug sales had been depressed by health reform legislation in 1989, the 1993 Health Structure Law and an economic recession.

Gehe decided it was in its best interests to evolve into an international drug wholesale group, whose widespread subsidiaries would attract multinational manufacturers.

In 1993 it acquired OCP and, as a result, almost doubled its turnover to DM10,176m. The full benefits were realised a year later, when Gehe's turnover rose to DM15,201m. In 1995 it acquired AAH Pharmaceuticals, whose Hills chain provided a foothold in the UK pharmacy market. Acquiring Lloyds Chemists turned that foothold into a dominant position – in sheer pharmacy numbers.

Much of these changes have come under Mr Kämmerer's stewardship. Having worked for IBM, mainly in finance for 16 years, he joined Gehe in 1980 as chief financial officer and, in 1993, was appointed chairman.

The UK acquisitions are arguably his most astute decisions. On one side, he has one of the country's top drug wholesalers. On the other, he has a cash generating machine in the form of Lloyds Pharmacy.

By encouraging the chain to acquire another 50 outlets a year until 2000, Mr Kämmerer wants

European wholesale market, 1998

Company	*Sales (DMbn)*
Gehe	21
Alliance Unichem	15
Phoenix	7
Tamro*	5

* Tamro operates only in the Nordic regions. Source: Gehe

to ensure it remains a major force.

A further bonus is the relatively strong UK drugs market, where sales have been growing faster than those in continental Europe for several years. Last year, for example, UK drug purchases rose 8 per cent.

While Gehe remains predominantly a wholesale group, it is ideally poised to take advantage of any future changes in European law concerning pharmacies.

Pharmacy chains are not allowed to exist in Germany and France – Europe's biggest pharmaceutical markets – nor does Mr Kämmerer see any change in the foreseeable future. But if the law does change, Gehe's UK experience with Lloyds Pharmacy could prove invaluable.

Pharmacy chains are allowed in Belgium, Switzerland and, to a limited extent, Italy. Mr Kämmerer does not rule out a deal in such markets. "Within the next three years, depending on the sale of pharmacies, we might get a foot in elsewhere," he says.

Where does that leave Gehe now? While Mr Kämmerer says he has "two or three" wholesale projects in the pipeline, he rules out any major acquisitions for a while. "We're going through a consolidation phase, where we would like to see all the benefits of our large acquisitions," he says. "It needs all the attention of our management. You cannot detract their attention permanently through new, large acquisitions."

Gehe's share of the European drug wholesale market, he adds, will not change drastically over the next few years. "We'll try to increase our shares of smaller markets through minor acquisitions," he says.

He believes Poland and Hungary have strong drug markets, but says no-one knows how they will develop. Gehe is, therefore, content to concentrate on its large, stable markets.

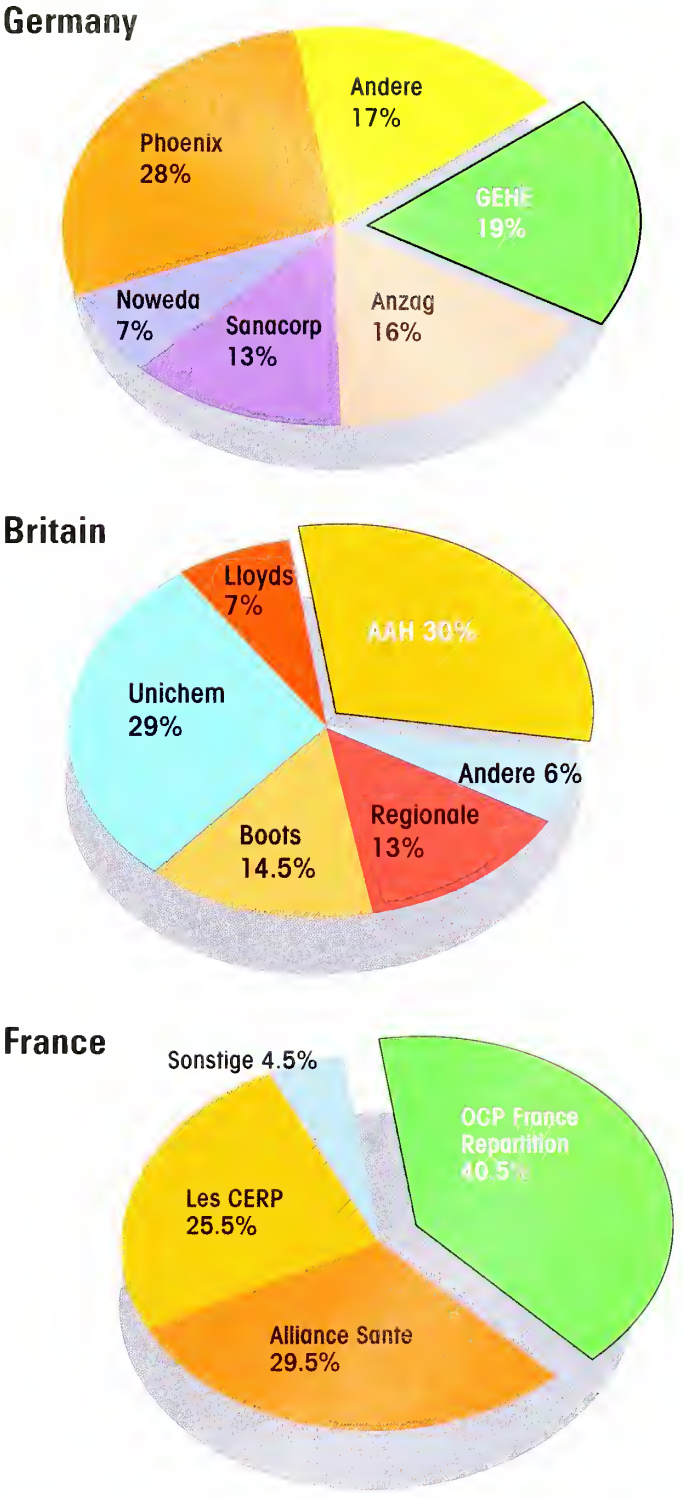
It is not a leading figure in all its markets. In Italy, Gehe has a drug wholesale subsidiary in Rome and is one of many wholesalers in the fragmented national market, although it claims a 20 per cent share in Rome's region.

Unichem's merger with Alliance Santé late last year has created another major pan-European health care group, but Mr Kämmerer appears unfazed by that development. "They're not a threat. I felt it was a good development when I heard the news because Alliance Santé is now under the roof of a publicly quoted company. Alliance Unichem will have to perform according to shareholder criteria – that makes me feel confident there will be a level playing field," he says.

Is Gehe not worried that AU could grab some of its European market? Mr Kämmerer smiles at the question. "They wouldn't try. They know us very well – it's not a good idea."

AU is an ideal platform for Unichem's plans to expand its pre-wholesaling interests, where products are distributed direct from manufacturers' plants. While Gehe has a pre-wholesaling business in France and two in the UK, one of which is Farillon, Mr Kämmerer sees little point in concentrating on this area.

"We don't consider European-wide pre-wholesaling as a strategy for two reasons. Firstly, it needs investment, which we cannot recover with our present structure. Secondly, we haven't found enough differentiating criteria which would give us a competitive advantage over a normal overnight carrier, or freight forwarder," he says.



Competition in the German wholesale market is tough, and the French market is expected to perform better next year.

'Feel good' factor on the wane

The pundits predict a soft landing for the economy – a downward turn in interest rates will help the Government achieve its 2.5 per cent inflation target

Although it is too early to be sure that interest rates have peaked, it looks as if the next significant adjustment to rates will be downwards, and that there will be no need for a prolonged period of below-trend growth to achieve the Government's medium-term inflation target of 2.5 per cent.

Recent concerns that growth would have to be sharply reined in – producing a drawn out recession and so-called 'hard landing' – have given way to the view that a more gentle and shorter slowdown will do the trick.

Although growth is set to continue decelerating for some months, it will pick up towards the end of the year, according to the latest indicator of future economic trends compiled by NTC Research. The fact that the indicator has not fallen below the long-term trend level, as it did before the last recession, suggests that the economy is "on course for a soft landing, with modest growth continuing into next year".

The Confederation of British Industry is also among the optimists. Kate Barker, its chief economic adviser, says: "We expect the economy will have a soft landing this year and next, as slower growth in domestic demand brings inflation back to the Government's 2.5 per cent target." Consumer spending is expected to grow by 4 per cent in 1998 and by 1.9 per cent in 1999.

Consumer confidence is certainly shaky. The MORI poll for April reveals a fall from the previous month, while a survey by Business Strategies shows that the edge has come off consumer optimism in nearly every region of the UK and is now back to pre-election levels.

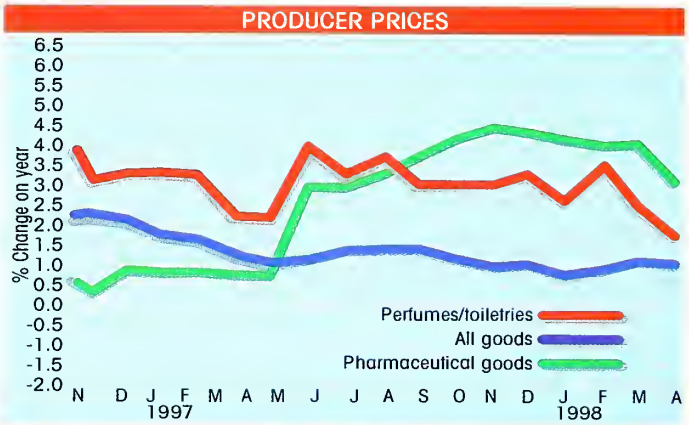
Official figures on consumer spending indicate a robust 1 per cent increase in the first quarter, to a level 5.1 per cent higher than a year ago. But retail sales growth, which rose by 0.8 per cent during the same period, appeared to lose momentum during the quarter, providing a weak foundation for second quarter growth.

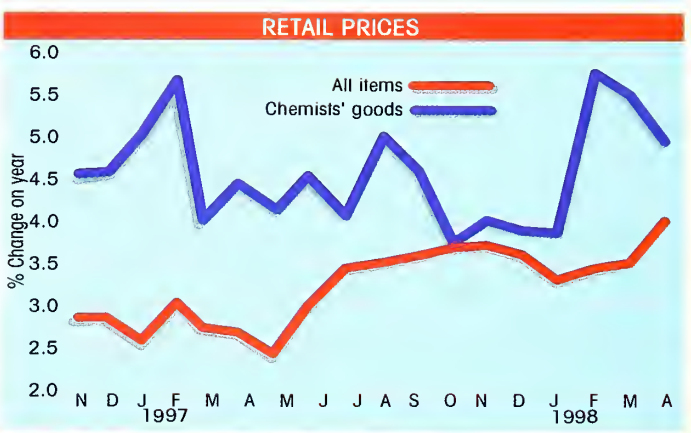
However, the monthly pattern has been affected by unseasonably warm weather, and the timing of Easter, so it could be several months before the underlying trend becomes clearer.

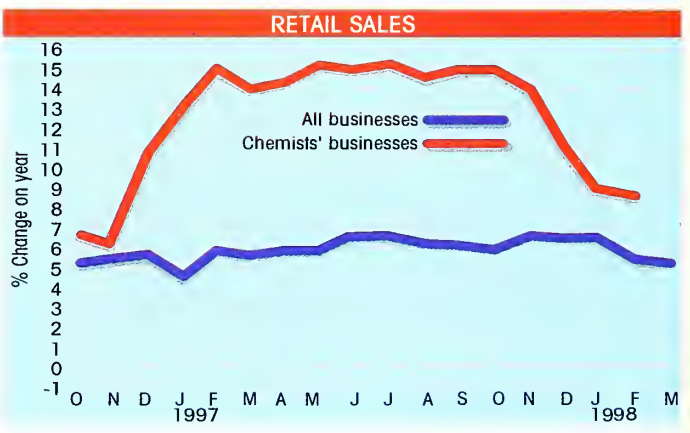
The CBI says that annual sales volume growth revived in April, following poor performance in March, although growth expectations are less buoyant than at the beginning of the year.

	Latest	% change on previous period	% change on previous 3 periods	% change on year
PRICES AND COSTS				
Retail prices				
All items	Apr	1.1	1.9	4.0
Chemists' goods	Apr	0.2	2.9	4.9
Producer prices				
Manufacturing industry, excl food	Apr	0.0	0.2	0.2
Chemical industry	Apr	-0.8	-0.8	-1.2
Pharmaceuticals	Apr	0.1	0.4	3.2
Perfumes & toilet preps	Apr	0.0	0.2	1.7
Lip & eye make-up preparations	Apr	0.0	-4.1	-5.8
Dental & oral hygiene preps	Apr	0.0	0.0	3.1
Shaving preps, deodorants	Apr	-0.1	-0.8	1.2
Adhesive dressings	Apr	0.1	0.3	0.6
Average earnings				
Whole economy	Mar	1.0	1.9	5.4
Chemicals, chemical products	Mar	13.4	10.3	9.4
OUTPUT				
Chemicals, man-made fibres	Q1	-0.9	-0.6	-1.9
Pharmaceutical products	Q1	-0.4	1.7	-0.8
Perfumes, cosmetics, toiletries	Q1	5.1	-11.7	-12.2
SALES				
Consumer expenditure (constant prices)				
Total	Q1	1.0	3.2	5.1
Retail sales (current prices)				
All retail businesses	Apr	3.5	6.0	5.7
Pharmaceuts/toiletries/cosmetics	Mar	0.0	-29.1	9.1
OTHER BUSINESS INDICATORS				
Consumer credit – gross lending	**Mar**	**6.0**	**3.4**	**28.4**
Jobcentre vacancies	**Apr**	**-0.7**	**-12.2**	**-6.4**
Unemployment claimant count	**Apr**	**-1.3**	**-2.7**	**-18.8**

Sources: Office for National Statistics, Bank of England and C&D







In contrast, a balance of 30 per cent of chemists reported higher sales in April than a year before, compared with 44 per cent in March. In April 1997, the balance of chemists with improved year-on-year volumes was 43 per cent.

Official data for retail sales in April indicates only a small increase, with the largest gains in household goods. The British Retail Consortium's sales monitor provides further evidence that the slowdown has begun, and it says higher mortgage costs are making consumers "even more cautious and cost conscious".

But following a good month in March, April was also "a pretty good month overall" for the chemist and beauty sector. Medicines were up on last year, and cosmetics, skin care, hair and bath products all recorded healthy sales.

Retail prices of chemists' goods have declined steadily during the past three months, reaching 4.9 per cent in April, compared with overall retail price inflation of 4.0 per cent. British manufacturers' factory gate prices of pharmaceutical preparations are now 3.2 per cent higher than a year ago, and perfumes and toiletries are 1.7 per cent more expensive.

The industry's cost pressures remain generally weak. The cost of raw materials and fuel purchased by UK pharmaceutical manufacturers fell by 3 per cent in the year to April, while makers of perfumes and toilet preparations saw input costs decline by 2.3 per cent.

Insurance for the self-employed

Bristol-based Insurety, an insurance company, has launched a policy aimed at the self-employed and owners of small businesses.

The Talisman income replacement plan provides an income for up to 12 months, if the business fails, and up to 24 months to cover illnesses.

Insurety says the replacement income is paid from the first day after the initial waiting period of 14 or 30 days is over. An applicant's age or occupation, it adds, will not lead to higher premiums.

For further information, contact Insurety on 01932 414150.

Doncaster Pharmaceuticals has two reasons to pour out the champagne: this is its 20th anniversary and it has opened a 5,000 sq ft labelling unit next to its headquarters in Kirk Sandall, Doncaster. The unit will batch, label and process DP's parallel imports. Pictured (l-r) Richard Freudenberg, company secretary, Dorothy Bradley, deputy managing director, John Whitworth, managing director, Jeff Cox, qualified person, Bill Kent, operations director and Marie Pearson, sales director

AHP and Monsanto to merge

American Home Products (AHP) and Monsanto are set to merge into a life sciences group whose market capitalisation would be $96 billion ($60bn).

Under the deal, AHP will take over Monsanto, whose interests include pharmaceuticals, food ingredients and biotechnology.

AHP's core strengths include ethical and OTC drugs, biotechnology and animal health care. Its UK subsidiaries are Wyeth Laboratories and Whitehall Laboratories, both based in Taplow, Maidenhead.

Wyeth says it is too early to find out how its operations – and those of Whitehall – could be affected by the merger. AHP announced the deal in the US on Monday.

The merged group, which has not yet been named, would have an annual turnover of about $23bn, employ 75,000 and spend around $3bn a year on R&D.

It expects to cut its annual costs by $1.5bn within three years. John Stafford, AHP's chief executive, admits redundancies will follow among the global work force.

AHP shareholders will keep their shares, while Monsanto shareholders will receive 1.15 shares in the merged group for each Monsanto share. AHP shareholders will own about 65 per cent of the group's equity, while Monsanto shareholders will own the remainder.

John Stafford, AHP's chief executive and Robert Shapiro, Monsanto's chief executive, will be co-chairman and co-chief executives of the group. The 22-member board of the new group will be split equally between the two companies.

Mr Shapiro says the merged group has obvious advantages. "Our new company is designed to be successful in the face of increased consolidation and increasing worldwide competition in life sciences. We will have the scientific depth, global marketing capabilities and financial resources to take greater advantage of the opportunities before us – and to bring innovative new products to market faster," he says.

AHP has been looking for another deal since SmithKline Beecham pulled out of a planned merger, earlier this year, to attempt its ill-fated partnership with Glaxo Wellcome.

Assuming the deal is passed by US regulatory authorities and no other bidder steps in, the merger could be completed by the end of this year.

Unichem splits sales force into two groups

Unichem has restructured its sales force into two groups: one to service independent pharmacies and the other multiples.

The sales force for independents consists of 30 reps split into three divisions covering the north of England, the Midlands and southern England. It is being led by newly-appointed retail sales controller Alastair Maxwell.

Independent and national multiples are being serviced by a team of four reps. Paul Hassall is the team's new national account controller.

Nick Epps, Unichem's general manager for sales, says the company's overall approach to pharmacies will not change, "but it will be more targeted and there will be additional people on board to do the job".

Unichem's previous sales structure consisted of five line managers, 26 account development managers, five support managers and one national account manager.

The group has also introduced a sales training team headed by David Evans, its former sales operations manager.

Astra files lawsuit to protect Losec patent

Astra and Astra Merck, the company's US-based joint venture with Merck, have filed lawsuits against Andrx Pharmaceuticals and Genpharm to stop them launching generic versions of Losec.

The drug, marketed in the US as Prilosec, is Astra's best-selling drug. Its global sales last year rose 13 per cent to SKr21,526 bn.

Astra has managed to extend its patent on Prilosec, which was due to expire in 1999, to April, 2001 in the US.

While both Andrx and Genpharm want to launch their generic versions after April, 2001, Astra says these companies' drugs infringe several other Prilosec patents that do not expire until 2014.

NPA backs £3.60/hr

The National Pharmaceutical Association supports the Low Pay Commission's minimum wage recommendation of £3.60 an hour.

Valda Elson, the NPA's personnel and administration manager, says she is pleased with the Commission's rate. Most pharmacies, she adds, already pay above that level.

Diabetes support for pharmacists and patients

Boehringer Mannheim in association with CHEMIST & DRUGGIST

This week the third of five accredited modules on diabetes care is delivered with *Chemist & Druggist* as a 'pull-out-and-keep' section bound into the centre of the magazine.

Each module includes a question paper that can be evaluated using *C&D's* telephone marking system. Pharmacists who register with *C&D* will be issued with a PIN to access the system. Those who pass each module of the course will receive a Certificate. Boehringer Mannheim is meeting all administration costs, so all you need to do is complete the registration form below.

Each module has been registered with the College of Pharmacy Practice. Together the five modules provide six units towards the CPP's postgraduate learning requirement.

The modules will be delivered monthly with *C&D* from April to August in the first issue of each month. The telephone marking system will be available to registered users until December 31. Certificates will be posted out in February 1999.

The five modules comprising 'Diabetes Support for Life' are:-
- Classification and Diagnosis of Diabetes
- The Role of Insulin
- Control of Diabetes
- Health Promotion for Diabetic Patients
- Practical Pharmaceutical Care of Diabetics

Back issues of the modules are available direct from Boehringer Mannheim by phoning 0800 701000 or via their representatives.

Registration Form

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Pharmacy address

Post Code

Tel no. Fax no

Send this form to Sue Cheeseman, Pharmacy Group Special Projects, Freepost TN 2444, Miller Freeman UK Ltd, Tonbridge, Kent TN9 1BR

LIG enjoys double-digit growth

London International Group's (LIG) pre-tax profits, after adjusting for the impact of currency fluctuations and exceptionals, rose 14.6 per cent to $40.8 million on a turnover of $344.8m for the year to March 31.

Currency changes, such as the strong pound, cost the company $22.3m. LIG also incurred a loss of $12m through the sale of Cook Bates, a US-based manicure tool business.

Its UK condom sales, meanwhile, rose 6.3 per cent. LIG's overall family planning sales grew 9.2 per cent to $135.1m, while its branded condom sales rose 10.1 per cent to $112.9m. Unbranded condom sales were up 10.3 per cent to $18.2m.

LIG says Durex Avanti, the premium-priced brand it launched in December 1997, has grabbed about 4 per cent of the UK condom market's volume sales, and 11 per cent by value. The company estimates that UK consumers annually buy about 160m condoms – the market is worth around $58m. LIG says its share of the market is 75-80 per cent.

Its medical glove sales grew 17.5 per cent to $78.5m, while those of its non-core health and beauty products fell 3.8 per cent to $60.5m.

LIG expects to maintain its double-digit growth in the current financial year.

The news sent the company's shares up 15.5p to 212.5p.

ADVANCED INFORMATION

The Society of Pharmaceutical Medicine has organised a meeting on 'Medicines from plants' at the Institute of Biology, South Kensington, on **June 29**. Christopher Ryan. Tel: 0171 581 8333.

Complementary Therapy 1998 takes place at St George's Centre, Chatham Maritime, on **July 5**. Call 01795 536920.

The Society for Medicines Research has organised a stroke seminar at the Lilly Research Centre, Surrey, on **July 9**. Barbara Cavilla, SMR. Tel: 0171 581 8333.

IBC Global Conferences is holding a conference on **July 13/14**. 'Meeting regulatory requirements for patient information leaflets & labelling in Europe'. Call +44 (0) 711 453 2701.

NHS50 conference on 'Future of services for people with learning disabilities' at the Royal Society of Medicine, London, on **July 14**; and 'Caring for older people' at St Thomas Hospital, London, on **July 15**. Tel: 01892 519678.

The **FIP Congress '98** will now take place in The Hague, and not Cairo, from **August 31 to September 4**. Peter Zethner-Moller of FIP. Tel: +31 70 363 19 25.

Celltech £2.5m in profit...

Celltech reports a profit of £2.5 million for the six months to March 31 – it had a loss of £5.9m during the same period in 1996/97. A licensing income of £5.7m, added to the £10.5m Celltech received by selling its stake in Alusuisse-Lonza back to the company, contributed to the result. Celltech has also appointed Dr Melanie Lee as director of research.

... but Courtaulds profits fall

Courtaulds, the international chemical company, saw its pre-tax profits fall 17 per cent (before exceptionals) to £111m for the year to March 31. Its sales fell 6 per cent to £1.957bn. The company blames most of the slump on the strong pound.

Calling ANA

The Article Number Association, which is the UK's standards authority for bar coding and electronic data interchange, has changed its telephone numbers to: general enquiries: 0171 655 9000; member enquiries: 0171 655 9001.

COMING EVENTS

MONDAY, JUNE 8

WCPPE
Castle Hotel, Brecon – 'Oxygen Therapy'.

WEDNESDAY, JUNE 10

WCPPE
Rossett Hall Hotel, Chester Road, Rossett – 'Helicobacter, dyspepsia and pharmacists – how do they fit together?'

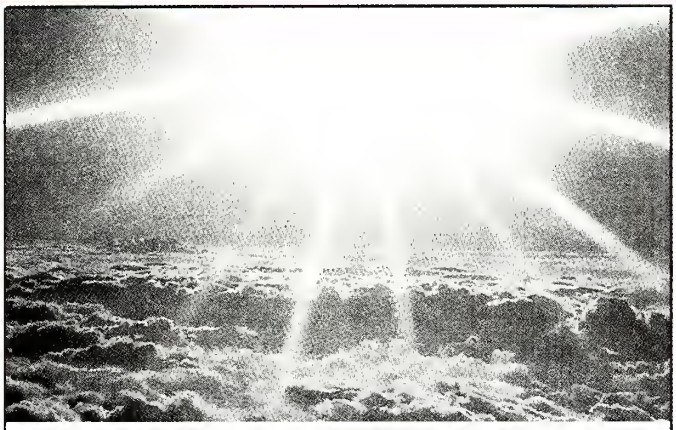
WCPPE
At the New House Country Hotel, Thornhill, Cardiff – 'Understanding the Three Cs (caps, condoms and contraceptives)'.

SATURDAY, JUNE 13

Derby Branch, RPSGB
Summer ball at the Mackworth Hotel, Derby.

Classified

APPOINTMENTS



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ABOUTpeople

Belfast marathon winner

Tommy Hughes, the warehouse manager for the Herons Chemist Group in Northern Ireland, won the 1998 Belfast Marathon last month

A warehouse manager for the Heron Chemists Group in Northern Ireland, Tommy Hughes, has won the Belfast Marathon.

Last month's win brought Mr Hughes a step nearer his goal of competing in his second Olympics in Sydney in the year 2000.

Mr Hughes has already represented Ireland in the Olympic Marathon at Barcelona in 1992.

It is the second time he has won the Belfast Marathon – the first was a decade ago.

He now has his sights set on winning the Dublin Marathon in October, in order to achieve another of his ambitions: winning these two races in the same year.

To put his talents in perspective, ten years ago he ran the London Marathon in a time of two hours 21 minutes to secure 55th place, a performance which he described as being 'not particularly good'.

"The people at Herons have been really pleased for me since I won the Belfast [Marathon]. Sydney will be great and won't be too cruel on runners – I hope I get the time off to go and compete," he says.

Lincoln Co-op funds kids' projects

The Lincoln Co-operative Society's pharmacy department is allocating half its £20,000 local community health care fund to projects involving children this year.

Last year, the organisation received over 70 applications for funds and gave 27 projects grants of between £180 and £2,000. This year, the Society has put £1,000 into the fund for every pharmacy it operates.

The LCS is splitting the sum into two major donations of £5,000 and ten minor ones of £1,000. It is advertising the scheme with posters in every pharmacy in the county and in surgeries, schools, libraries and community centres.

The health care fund was set up to return some of the benefits of prescription 'sales' to the community, because pharmacies are not allowed to give out dividend stamps for prescriptions.

The closing date for applications is July 31. For more information, contact: Peter McCree, Lincoln Co-operative Healthcare Fund, 15-23 Tentercroft Street, Lincoln LN5 7DB.

French pharmacists seek daughter exchange

Are you a pharmacist from Kent with a teenage daughter who wants to brush up her French? If so, then this could be for you.

A pharmacist couple in Nieppe, near Lille in northern France, would like their 15-year-old daughter to learn our language and culture, and would like to hear from a pharmacist who would like his or her daughter to learn the same about France.

Mr and Mrs Sepieter-Dekyndt are offering to look after a 14-16-year-old girl for a week this August, and regularly during the school holidays thereafter.

Nieppe is a small town in French Flanders (pop 7,500), not far from the Belgian border. Mr and Mrs Sepieter-Dekyndt plan to show their guest the region around Lille and Flanders in Belgium, where they own a cottage by the sea.

Mr and Mrs Sepieter-Dekyndt, who speak and write some English, can be contacted at: Pharmacie du Parc, 3 Rue D'Armentieres, 59850 Nieppe, France. Tel: 00 33 320 486 041. Fax: 00 33 320 485 099.

Kerry Pollard (left), MP for St Albans, paid his first visit to the National Pharmaceutical Association's headquarters, Mallinson House, on Monday. Mr Pollard, who has a strong interest in women's issues and diabetes, was presented with a model of an Edwardian pharmacy by the NPA's director John D'Arcy

Pre-reg travel award

The National Pharmaceutical Association is giving pre-registration students the chance to express their ideas and win a trip to the 1999 International Pharmaceutical Federation conference in Barcelona.

To take part, students must write a maximum of 5,000 words on: 'Balancing act – health care professional or retail manager', before August 1. The judges are looking for interesting, entertaining and innovative submissions.

The new Tim Astill annual travel award covers delegate registration fees, air fares, transfer fees, and hotel costs.

Entries should be sent to: The National Pharmaceutical Association, re: TPA Award – public affairs department, Mallinson House, 38-42 St Peter's Street, St Albans, Herts AL1 3NP.

An opportunistic visit by Barbara Follett, the Labour MP for Stevenage, to West Herts Local Pharmaceutical Committee's smokealyser stand at Hertfordshire Health Promotion's anti-smoking summit earlier this year led to an invitation for pharmacists to discuss RPM at the House of Commons this month. Mrs Follett and council leader Brian Hall (centre) tested their carbon monoxide levels at the LPC's stand watched by LPC chairman Colin Freidland (left), Stevenage mayor Ken Vale and LPC vice chairman Gary Elton (right)

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- Pharmacyupdate training modules now appear regularly
- Printable question papers are also included
- Newcomers will find a two-part introduction to the internet
- The latest dates and venues for exhibitions and conferences can be found here
- There are links to other WWW sites of interest to pharmacists
- Quarterly Business Trend Survey figures are a regular feature
- Features include '2000, the computer nightmare' and other key articles

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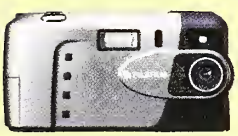

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To register your entry, send a photograph of your display with your name, title, address and telephone number on the back, to: Pharmacy Competition, Boehringer Mannheim UK Ltd, Bell Lane, Lewes, East Sussex BN7 1LG. The closing date for entries is July 31, 1998.

Conditions of entry:

This competition is open to pharmacists only. Entries received after the closing date will not be valid; the display must stay in situ for one month from the date of entry; the winners will be the senders of the 5 entries deemed to be the most creative Glucotrend displays. The judges decision is final; no correspondence will be entered into; there will be 5 prizes of digital cameras; there will be no cash alternative; the winners will be notified by post by August 31, 1998; a list of winners may be obtained by sending a stamped addressed envelope to the entry address after the closing date; entries will not be returned.

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